

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36224**
Registrar's No. **8794**

FILED OCT 16 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		• STREET ADDRESS (If rural, give location) 23812 Wyoming	
3. NAME OF DECEASED (Type or Print) Elizabeth		a. (First) Elizabeth	b. (Middle) Solari
4. DATE OF DEATH Sept 22 1956		5. SEX female	
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH Oct. 28, 1869		9. AGE (In years last birthday) 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Essen, Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME otto Moureau		13b. MOTHER'S MAIDEN NAME Wilhelmina Kessel	
14. NAME OF HUSBAND OR WIFE Florence		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Florence Solari	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) METASTATIC CARCINOMA LUNGS ANTECEDENT CAUSES DUE TO (b) CARCINOMA UTERINE DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS ARTERIOSCLEROTIC HEART DISEASE	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 174X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 6-8-1956 , to 9-23-1956 , that I last saw the deceased alive on 9-23-1956 , and that death occurred at 7:45p m., from the causes and on the date stated above.	
23a. SIGNATURE Robert S. Warner M.D.		23b. ADDRESS 518 OLIVE	
23c. DATE SIGNED 9/24/56		24a. BURIAL, CREMATION, REMOVAL (Specify) removal	
24b. DATE Sept 25, 1956		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		DATE REC'D BY LOCAL REG. SEP 24 1956	
REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	
ADDRESS 3. D.		ADDRESS 7027 Gravois	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

3. D. (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Donald E. Benz*.....

Licensed Embalmer No. *4863*.....

P. O. Address *7027 Grand*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**