

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36387

FILED OCT 16 1956

318

1003

STATE FILE NUMBER 8695

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Parklane Hosp.			Length of stay in lb		d. STREET ADDRESS (If outside, give location) 4405 Wallace Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAUDE				First M.		Middle WESTER		
4. DATE OF DEATH Sep. 19 1956				Month Sep.		Day 19 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1893		9. AGE (In years last birthday) 63		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria Worker-Parklane Hosp.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Lewis				14. MOTHER'S MAIDEN NAME Anna Woodcock				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Isabell Wester		Address 4405 Wallace Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus; Fracture of Right Femur; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 9047 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 11							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Injured in fall at Park Lane Hospital while working at Park Lane Hospital on Sept 2, 1956					
20c. TIME OF INJURY Hour 9.2 Month, Day, Year 2. 1956			20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hosp		20f. CITY, TOWN, OR LOCATION St Louis Mo	
21. I attended the deceased from _____ to _____ and last saw her/him _____ Death occurred at 10:30 a. m. on the _____ day stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Type or print) Joseph M. Smith				22b. ADDRESS 1300 Clair		22c. DATE SIGNED 9/21/56		
23a. BURIAL, CREATION, REMOVAL (Specify) Removal		23b. DATE Sep. 22, 1956	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
24. FUNERAL DIRECTOR Kriegshauser				ADDRESS 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. SEP 20 1956		
26. REGISTRAR'S SIGNATURE Carl Smith mo <i>mjb</i>								

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Edwin H. Mc...*.....

Licensed Embalmer No. *301*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.