

FILED DEC 20 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER 42870  
10653

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN PINE LAWN 4151		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JEWISH HOSPITAL			Length of stay in lb		d. STREET ADDRESS 3744 SALOME		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MARIETTA CORLESS				4. DATE OF DEATH Month Day Year NOV. 19, 1956					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1907		9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) UNKNOWN ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME ERNEST LINDSEY				14. MOTHER'S MAIDEN NAME EDITH SERELS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown) NO.		16. SOCIAL SECURITY NO. #492-01-2510		17. INFORMANT Address OLIVER CORLESS 3744 SALOME					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral vascular accident</i>							INTERVAL BETWEEN ONSET AND DEATH 48 hours		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>possible brain metastases</i>				?			
		DUE TO (c) <i>old carcinoma ovary</i>				Several years			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input 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.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <i>Aug 8/56</i> to <i>Nov 19/56</i> and last saw her alive on <i>Nov 19/56</i> . Death occurred at <i>7:30</i> <i>PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Frank Cohen (M.D.)</i>				22b. ADDRESS <i>1127 Pine St St Louis Mo</i>				22c. DATE SIGNED <i>11/21/56</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-23-56	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.				
24. FUNERAL DIRECTOR ADDRESS STROOT CARROLL 4600 NAT. BRIDGE				25. DATE RECD. BY LOCAL REG. NOV 21 1956		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>			

(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms were observed prior to death.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DR FRANK COHEN

~~5899 DELTA~~

~~2-1-8105~~

~~3:00 PM~~

~~12.9-1308~~

~~Office~~

1 for Wood

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 M. W. R. meter

Licensed Embalmer No. 48

P. O. Address St Louis

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.