

FILED FEB 6 1957

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

3237

STATE FILE NUMBER

 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>		c. CITY OR TOWN <u>Overland</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Overland Restorium</u>		Length of stay in lb <u>6 Months</u>	d. STREET (If outside, give location) ADDRESS <u>10460 Thorpe Ave.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
<u>Elizabeth</u>			<u>Jan. 9, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1875</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			IF UNDER 24 HRS. Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Krakow Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ben Voss</u>			14. MOTHER'S MAIDEN NAME <u>Wilhemenia Popp</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No Nil</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Helen Ballmann 10028 Breckenridge Ave.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>		Overland Mo.	INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, bronchitis</u>			<u>3 days</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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 <u>1-10-56</u> to <u>1-19-57</u> and last saw her alive on <u>1-8-57</u> Death occurred at <u>7:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. H. Moller MD</u>			22b. ADDRESS <u>2438 Woodson Rd</u>		22c. DATE SIGNED <u>1/10/57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-10-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	23d. LOCATION (City, town, or county) <u>Krakow</u>	(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe 4704 Washington Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>1-10-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Dombek MD</u>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Health
 Welfare
 Public
 Service

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 *John J. Haine*
Licensed Embalmer No. *416*
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.