

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029923

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7809 STATE FILE NUMBER

**FILED AUG 9 1963**

1. PLACE OF DEATH  
a. COUNTY Missouri b. CITY OR TOWN St. Louis

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 Length of stay in 1b c. CITY OR TOWN Wellston Inside Limits Yes  No

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hos Inside Limits Yes  No  d. STREET ADDRESS (If outside, give location) 1513 Wellston Ave. Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last Mary C Filla 4. DATE OF DEATH Month Day Year 7-30-63

5. SEX Female 6. COLOR OR RACE White 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 9-20-1888 9. AGE (last birthday) 74

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (City and state or country) Ill. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME William Curran 13b. MOTHER'S MAIDEN NAME Caroline Kalner 14. NAME OF HUSBAND OR WIFE Thomas F Filla

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Address Thomas Filla 1513 Wellston Ave.

18. CAUSE OF DEATH (Enter only one cause per line)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebral hemorrhage  
DUE TO (b) Neoplasm (Pt) Diabetic (1954) 1958  
DUE TO (c) Ununited dental root in maxillary (Pt) 1962  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 904.745  
PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT SUICIDE HOMICIDE    20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) FELL AT NURSING HOME

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 6-5-62

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE  
Nursing Home St. Louis Mo

21. I attended the deceased from 1944 to 7-30-63 and last saw her alive on 7-29-63  
Death occurred at 2:00a m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree Title) 21b. ADDRESS 21c. DATE SIGNED  
Walter S. Prue M.D. 7449 W. Florissant St. Mo 7-30-63

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)  
Burial 8-2-63 Calvary Cemetery St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE  
J.W. Clark F.H. 1125 Hodiamont Ave. JUL 31 1963 Neal Smith, M.D.

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Dr. H. Pruett  
7449 West Florissant  
4-6pm.

**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 \_\_\_\_\_

Licensed Embalmer No. 4514

P. O. Address St. Louis, Mo.

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.