DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

34059

State File No. 8597

Registration District No. 791 1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County 2

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5930 Nashville (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL") 4

(d) Street No. 5930 Nashville (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Cecelia Heras 620

3. (b) If veteran, name war

3. (c) Social Security No. 497-03-0168

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased September 29, 1887 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	0	7	hr. min.

9. Birthplace New Orleans (City, town, or county) La. (State or foreign country)

10. Usual occupation Hat worker 1

11. Industry or business

FATHER
12. Name ? Stevens 9
13. Birthplace (City, town, or county) Unknown (State or foreign country) 2

MOTHER
14. Maiden name Unknown Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature X James Heras

(b) Address 5930 Nashville

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/39 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Edith E. Ambruster

(b) Address 4234 Manchester

19. (a) OCT 7 1939 (Date received local registrar) (b) J. F. Bachek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6 year 1939 hour 12.10 A.M. minute M.

21. I hereby certify that I attended the deceased from May 15, 39 May 15, 1939, to Oct 6th, 1939; that I last saw her alive on Oct 4th, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Liver

Due to Exhaustion + Obstruction of bowels

Due to

Other conditions — (Include pregnancy within 3 months of death)

Major findings: Of operations She was operated at Barnard Hospital about Mos ago

Of autopsy no

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature A H Hamel (M. D. or other) 1

Address 1460 So Grand Av Date signed 10/6/39

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.