

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38281
Registrar's No. 10120

Registration District No. _____ Primary Registration District 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: 4201 Wyoming
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Marie Detjen 225
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Otto 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Nov 18 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months 0 Days 7 If less than one day hr. _____ min. _____

9. Birthplace Berlin Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 6
MOTHER FATHER { 12. Name (unk) Thiele 6
13. Birthplace Not known Germany 6
(City, town, or county) (State or foreign country)
14. Maiden name (unk) Hinz 6
15. Birthplace Not known Germany 6
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marie Detjen
(b) Address 4201 Wyoming

17. (a) burial (b) Date thereof 11/28/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Pk.

18. (a) Signature of funeral director J. F. Brudick
(b) Address 7027 Gravois

19. (a) NOV 28 1939 (b) J. F. Brudick
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 4201 Wyoming
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 40 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 25
year 1939 hour 7 minute 30 p. M.

21. I hereby certify that I attended the deceased from March 20, 1929, to Nov. 25, 1939;
that I last saw her alive on Nov 25, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Papillary adenocarcinoma of ovary. Duration _____
Metastases in tubes, uterus & cranium.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 6/15/39 - above condition
Of operations Hysterectomy
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. F. Plag (M. D. or other) _____
Address 3150 Morganford Rd Date signed 11/27/39

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..... *C. P. Kidwell*

Licensed Embalmer No. *3 877*

P. O. Address *6937^a Gravois*

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.