

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. **8843**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **2326**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Josephine Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Rose Hall

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife James Hall 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 4 1870  
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation HOBB Housekeeper

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name Frank McCormick

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Rose Hart

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant John McCormick  
 (b) Address 5448 Murdoch

17. (a) Burial (b) Date thereof 3/11/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director E. J. Schmur

(b) Address E. J. Schmur 3025 Lafayette

19. (a) MAR 9 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 14  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5448 Murdoch Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7  
 year 1940 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from 2-24-40  
 \_\_\_\_\_ 19 \_\_\_\_\_ to 3-7-40 \_\_\_\_\_  
 that I last saw her alive on 3-7-40  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Gall bladder cholecystitis  
 Duration 10 days  
10 yrs?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Renovator  
(Include pregnancy within 3 months of death) 2 days

Major findings: Pneumonia Gall bladder stones  
 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 J. J. Schmur (M. D. or other) \_\_\_\_\_  
 Address 1802 So Grand Dge signed 2326

**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.....

*Joseph Wollmer*

Licensed Embalmer No. *4014*

P. O. Address *3125 La Fayette Ave*

**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.**