

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **84267**
Registrar's No. **8964**

Registration District No. **791**

Primary Registration District No. **1003**

PLACE OF DEATH:

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

8. (a) PRINT FULL NAME **Margaret Hanna**

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 **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 8 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 1 23 hr. min.

9. Birthplace **St. Louis Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home: 4**

11. Industry or business _____

12. Name **James Hanna** 1
18. Birthplace **Glasgow Scotland**
(City, town, or county) (State or foreign country)

14. Maiden name **Rosella Jones**
15. Birthplace **Templeton Mass.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Hanna**
(b) Address **12 Washington Terrace**

17. (a) **Cremation** (b) Date thereof **10/31/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Crematory**

18. (a) Signature of funeral director **Wagoner Und. Co.**

(b) Address **3621 Olive, St Louis, Mo.**

19. (a) **OCT 31 1940** (b) **J. J. [Signature]**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis.** **12**
(If outside city or town limits, write "RURAL")
(d) Street No. **12 Washington Terrace**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **31**
year **1940** hour **6** minute **a** M.

21. I hereby certify that I attended the deceased from **Feb 1**
_____, 1940, to **Oct. 31**, 1940;

that I last saw him alive on **Oct 30**, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cancer of the breast **2 years**

Due to _____

Due to _____

Other conditions (Include pregnancy within 8 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 **Albert E. Tausig** (M. D. or other) **M. D.**

Address **4500 Olive St. St. Louis** Date signed **10/31/40**

Not embalmed @

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 the above constitutes grounds for revocation of license.)

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