

No. 2
4-13-40
5-17-39
X211

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27021

State File No.

FILED SEP 17 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6813

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:
City Hospital # 1 ()
(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..... 000

(c) City or town..... St. Louis 2317
(If outside city or town limits, write "RURAL")

(d) Street No. 902a Rutger St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Sarah Rider

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Charles

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

7. Birth date of deceased: June 10 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68	2	10	hr. min.
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9. Birthplace Carterville / Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry of business.....

12. Name William J. Dowell

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

14. Maiden name Mary E. Robinson

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

16. (a) Informant Daphne Rueb

(b) Address 2912 Minnesota

17. (a) Removal (b) Date thereof 8/22/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) AUG 21 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 20
year 1941 hour 9:0 minute 45 P.M.

21. I hereby certify that I attended the deceased from May, 1938, to Aug 8, 1941
that I last saw h. alive on Aug 14, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Duration 2 hours
non tubercular non malignant

Due to Chronic Cardiac (hypertensive) central Regurgitation

Due to arterio-sclerosis
due to ruptured blood vessel

Other conditions Cardiac Asthma
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations.....

Of autopsy [Signature]

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 [Signature] (M. D. or other) FRAZER
Address 1109 A Chouteau Date signed 8/21/41

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

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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.....

Hubert H. Burnley

..... Licensed Embalmer No. 4209.....

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, fact should be so stated above.