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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29915

Filed OCT 14 1941
791
Registration District No.

Primary Registration District No. 1003

Registrar's No. 7254

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

1. 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: ST. LOUIS CITY HOSPITAL
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 13 yrs.
years, months or days)

3. (a) PRINT FULL NAME SARAH HECKARD
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 JAMES HECKARD
6. (c) Age of husband or wife if alive pink years
7. Birth date of deceased FEB 4
(Month) (Day) (Year)

8. AGE: Years 51 Months 6 Days 26
If less than one day hr. min.

9. Birthplace NEWTON ILL
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER
12. Name FRANCIS ALLWOOD
13. Birthplace ENGLAND Y
(City, town, or county) (State or foreign country)
14. Maiden name ELIZA BALK
15. Birthplace ILL I
(City, town, or county) (State or foreign country)

16. (a) Informant JAMES HECKARD
(b) Address 1714 Bacon St.

17. (a) Funeral (b) Date thereof 9 2 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chaffee Cem. Park Mrs. B. B. Bredich
18. (a) Signature of funeral director B. B. Bredich
(b) Address Chaffee Ind.

19. (a) SEP 8 1941 (b) J. Bredich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town ST. LOUIS 11 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1714 BACON ST. 9
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 30
year 41 hour 7 minute 40 P. M.
21. I hereby certify that I attended the deceased from 8/24/41
to 8/30/41, 1941;
that I last saw her alive on 8/30/41, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 61
Major findings: Of operations 10
Of autopsy 11
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 B. Bredich (M. D. or other) D
Address 1515 Lafayette St. Date signed 8/26/41

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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 *John Ketter*
Licensed Embalmer No. *3880*
P. O. Address *St. Louis 7*

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.

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **FILED OCT 18 1941**

Primary Registration District No. _____

Registrar's No. **2254**

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hosp
(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

3. (a) PRINT FULL NAME Sarah Weckard

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-8-41 (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month 8 day 30 year 41 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to _____

Due to 61

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 59

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

29915