S. No. 2
—11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

Registration District No. 784

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 3374

Primary Registration District No. 111

Registrar's No. 65

**1. PLACE OF DEATH:**

(a) County: St. Louis

(b) City or town: Richmond Hights, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo. (b) County: 000 17 9

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

(d) Street No.: 5128 Minerva Ave.,
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Emma M. La Croix.

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: Single

6. (b) Name of husband or wife: ____

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

7. Birth date of deceased: Dec. 8, 1850. (Month) (Day) (Year)

8. AGE: Years 92 | Months 1 | Days 0 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Retired

11. Industry or business: ____

FATHER
12. Name: John La Croix
13. Birthplace: Don't Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Josephine McDonald.
15. Birthplace: Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Ella Lichtendahl
(b) Address: 6009 Etzel Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 11/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cem.,

18. (a) Signature of funeral director: Jos. W. Clark
(b) Address: 1125 Hodiamont Ave.,

19. (a) JAN 12 1943 (Date received local registrar) (b) C. G. McGavran (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan. day 8 year 1943 hour 5.25 minute P.M. M.

21. I hereby certify that I attended the deceased from Dec 1, 1942, to Jan 8, 1943, that I last saw her alive on Jan 8, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death — Pneumonia Lobar Left Lower Lobe

Due to ____

Due to ____

Other conditions: Senility (Include pregnancy within 3 months of death)

Major findings:
Of operations: None

Of autopsy: ____

Duration

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: Benjamin Phillips M. D. or other M.D.
Address: City Barnsdall Date signed 1/9/43

(Licensed Embalmer's Statement on Reverse Side)

Dr. P.J.Reilly

**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. 3225

P. O. Address 1125 Hodiamont Ave.,

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

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