S. No. 2
M—5-42
6-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 3415

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 150

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mother Good Counsel 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Years (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Louis 96
(c) City or town Pine Lawn 0
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mary Gnagi
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 widowed
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 10 (Day) 1855 (Year)
8. AGE: Years 87 Months 1 Days 28 If less than one day hr. min.
9. Birthplace Westphalia (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant Walter Gnagi
(b) Address 1735 Pennsylvania
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-43 (Month) (Day) (Year)
(c) Place: burial or cremation Slater Mo
18. (a) Signature of funeral director Albert H Hoppe
(b) Address 4700 Washington Ave
19. (a) JAN 19 1943 (Date received local registrar) (b) C. G. McNamara (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18th year 1943 hour 5:15 minute M.
21. I hereby certify that I attended the deceased from 10/2/1939 to Jan- 17th, 19, to 1943 19 43 that I last saw her alive on Jan-17th, 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Apoplexy | 4 days |
| left, Hemiplegia rt. Chro- | 4 days. |
| Hypertension- Chro- Cardio- | |
| Due to Vascular Renal disease | |
| Chro- Int-Nephritis- Chro-Myo | |
| Carditis- Chro-Arterio-Sclerosis | |
| Due to All extreme senile condition | |

Other conditions
(Include pregnancy within 3 months of death)
Died at the Home of The Incurables
Major findings:
Of operations
Of autopsy NO

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) None
(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 (M. D. or other)
Address Jerseyville Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

## 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 Albert H. Hopper

Licensed Embalmer No. 1861

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.**