

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 16 1943  
818

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 1126

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:  
Park Lane Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Iora Craver Choate

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 married

6. (b) Name of husband or wife John W. Choate 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Jan. 27, 1896  
(Month) (Day) (Year)

8. AGE: Years 47 Months 0 Days 5 If less than one day  
..... hr. .... min.

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

10. Usual occupation At home

11. Industry or business Housewife

12. Name Dallas Beauchamp

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

14. Maiden name Bartha Washburn  
(City, town, or county) (State or foreign country)  
15. Birthplace Hardin, Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant Otis L. Choate

(b) Address 5118a Page Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane.

19. (a) FEB 4 1943 (Date received local registration) J. F. Breneck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL.")  
(d) Street No. 5118a Page Avenue (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or-No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 2,  
year 1943 hour 2 minute P.M.

21. I hereby certify that I attended the deceased from 1/28/43, 19....., to 2/2/43, 19.....;  
that I last saw her alive on 2/2/43, 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death Surgical Shock Duration 1 day

Due to Failed operations for fibroid of uterus  
Due to non-malignant

Other conditions Chronic appendicitis  
(Include pregnancy within 3 months of death)

Major findings 2/1/43 Fibroid  
Of operations Tumor of uterus  
Of autopsy No autopsy  
12/11

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?

While at work..... (Specify type of place) (e) Means of injury.....  
23. Signature John D. Hayward (M. D. or D.O.)  
Address Metropolitan Bldg. Date signed 2/3/43

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

MOTHER FATHER

**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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**