

269
S. No. 2
M-542
V-5-17-33
F-1 X-237

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16011**
Registrar's No. **4358**

DECEASED **MAY 18 1943** **318**

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(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 or location)
(d) Length of stay: In hospital or institution **7 Days** (Specify whether
In this community **23 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1837, Kennett** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Blanche Derry**

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 **Pete Derry** 6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **10 5 1908**
(Month) (Day) (Year)

8. AGE: Years **34** Months **7** Days **5** If less than one day _____ hr. _____ min.

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

10. Usual occupation **House-Wife**

11. Industry or business **At Home**

MOTHER FATHER }
12. Name **Robert Rhea**
13. Birthplace **Missouri** (City, town, or county) (State or foreign country)
14. Maiden name **Minnie Conley**
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Pete Derry**
(b) Address **1837, Kennett**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5 / 12 / 43**
(Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus**

18. (a) Signature of funeral director **A. W. McLaughlin**

(b) Address **2301 Lafayette**

19. (a) **MAY 11 1943** (Date received local registrar) **J. F. Bussack** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **10**, year **1943** hour **9:30** minute **A. M.**

21. I hereby certify that I attended the deceased from **May 4**, 19**43** to **May 10**, 19**43**; that I last saw her alive on **May 10**, 19**43**; and that death occurred on the date and hour stated above.

Immediate cause of death: **Pulmonary Tuberculosis**

Due to _____
Due to _____

Other conditions: **1/3**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy **refused**

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Laurel S. Neudorff, M.D.**
Address **1515 Lafayette Avenue** Date signed **5/10/43**

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 Paul A. Kerth
Licensed Embalmer No. 3612
P. O. Address 2317 Lafayette

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.