

No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

36092

State File No. _____

FILED DEC 13 1943
318

Registrar's No. 10568

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Good Samaritan Home - 4500 Washington
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Yrs.
In this community Life. 5 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sophia Bade

3. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

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

7. Birth date of deceased December 28 1861
(Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 3
If less than one day _____ hr. _____ min.

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

10. Usual occupation At home.

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Good Samaritan Home

(b) Address 4500 Washington Ave.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 12/3/43
(Month) (Day) (Year)

(c) Place: burial or cremation N. St. Marcus Cem.

18. (a) Signature of funeral director John S. Ziegenhein & Sons

(b) Address 7027 Gravois Ave.

19. (a) DEC 2 1943 (Date received local registrar)

J. F. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 4500 Washington Ave., 17
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1st. year 1943. hour 7 minute 12 A. M.

21. I hereby certify that I attended the deceased from Jan 12 1943, to 12-1- 1943
that I last saw her alive on 12-1- 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Hypertension
Atherosclerosis

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None

Of operations _____

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? _____

While at work? None
(Specify type of plant or business) (Specify type of injury)

23. Signature W. H. Miller (M. D. or other)

Address 811 5th Grand Date signed 12/1/43

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

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.....

C. P. Kedwell

Licensed Embalmer No. *3877*

P. O. Address *7027 Gravois*

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.