

No. 2
1-5-43
1-17-39
X36671

FILED DEC 9 1943
Registration District No. **318** Primary Registration District No. **1003**

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:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **0**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Margie Genna**
(b) If veteran, name war **None**
(c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **yes**
6. (b) Name of husband or wife **Joseph Genna** 6. (c) Age of husband or wife if alive **27** years
7. Birth date of deceased **August 30, 1921**
(Month) (Day) (Year)

8. AGE: Years **22** Months **2** Days **28**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Metal Worker & Riviter**

11. Industry or business **Curtiss Wright Aircraft Co.**

12. Name **Patrick Reyburn.**

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

14. Maiden name **Olsa Fischer.**

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

16. (a) Informant **Joseph Genna**
(b) Address **4971a Fountain Ave.**

17. (a) **Burial** (b) Date thereof **Dec. 2, 1943.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Joseph Genna**
(b) Address **1431 Union Bldg**

19. (a) **NOV 29 1943** (b) **J. F. Break**
(Date received local registrar) (Registrar's signature)

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. **4971a Fountain Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **28**
year **1943** hour **10** minute **a.** M.

21. I hereby certify that I attended the deceased from **May 1** 19**43** to **Nov. 28** 19**43**
that I last saw her alive on **Nov. 28** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary embolism 1 hr**
Due to **Post partum**
Due to **Normal labor 11/18/43**
Other conditions **Pregnancy**
(Include pregnancy within 3 months of death)

Major findings: **PHI**
Of operations _____
Of autopsy **Pulmonary embolism, Normal contractions**

22. If death was due to external causes, fill in the following: **Stomach**
(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?

23. Signature **H. H. Helbing** (M. D. or other) **MD**
Address **4963 Fountain** Date signed **11/28/43**

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. llc
Registrar's No. 10439

Registration District No. 218 Primary Registration District No. 1003

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:

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

In this community..... years, months or days)

3. (a) PRINT FULL NAME..... Margie Emma
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..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years..... Months..... Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (d) (Burial, cremation, or removal) (b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....
19. (c) EC 14 1943 (b) J. F. Buddeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... Year..... Hour..... Minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., that I last saw him/her alive on....., 19....., and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

36388