

S. No. 2
M-5-43
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36483**
Registrar's No. **10469**

FILED DEC 9 1943
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:
St. Johns Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution **3 weeks**
In this community **0** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Rose Harger**
3. (b) If veteran, name war **NO**
3. (c) Social Security No. **NO**

4. Sex **female**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **1874** years
7. Birth date of deceased **July 3** (Month) (Day) (Year)

8. AGE: Years **69** Months **4** Days **24**
If less than one day hr. min.

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

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER {
12. Name **Benjamin Ray**
13. Birthplace **Indiana**
(State or foreign country)
14. Maiden name **Maranda Beall**
15. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mildred Callaway**
(b) Address **108 Rose Acre Lane**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov. 30 1943**
(Month) (Day) (Year)
(c) Place: burial or cremation **Roam Indiana Jay B. Smith**

18. (a) Signature of funeral director **7456 Manchester Ave.**
(b) Address

19. (a) **NOV 22 1943** (Date received) (b) **J. F. Bredeek** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Webster Groves**
(If outside city or town limits, write "RURAL")
(d) Street No. **108 Rose Acre Lane**
(If rural, give location) **N.R.**
(e) Citizen of foreign country? (Yes or No) **1**
If yes, name country

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month **Nov.** day **27**
year **1943** hour **11** minute **P** M.
21. I hereby certify that I attended the deceased from **9/15/43**
19. to **11/27** 19. **43**
that I last saw her alive on **11/27** 19. **43**
and that death occurred on the date and hour stated above.

Immediate cause of death:
Hypertensive Cardiovascular Disease + cerebral hemorrhage

Due to **63**

Other conditions: **Hypertension**
(Include pregnancy within 6 months of death) **1 yr.**

Major findings: **Tropic Goitre removed**
Of operations **10/10/43**
Of autopsy **None**

Duration
1 yr.
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 **J. A. Munnich** (M. D. certifier)
Address **634 N Grand** Date signed **11/27/43**

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

10469 69701

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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 3457

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3457

P. O. Address Maplewood

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.