

S. No. 2
M-2-43
5-17-39
X3597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39119
State File No. _____
Registrar's No. 2522

FILED NOV 20 1943

Registration District No. 317

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3850 Nelson Drive
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Pine Lawn 0
(If outside city or town limits, write "RURAL")

(d) Street No. 3850 Nelson Drive
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary G. Hearne

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, Widowed 2

6. (b) Name of husband or wife Fred W. Hearne

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

7. Birth date of deceased August 2, 1864.
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12th,
year 1943 hour 5:55 minute A. M.

21. I hereby certify that I attended the deceased from _____
1943 to Nov. 12, 1943.
that I last saw her alive on Nov. 11, 1943, 19____;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>3</u>	<u>10</u>	hr. _____ min.

9. Birthplace New Orleans, Louisiana. /
(City, town, or county) (State or foreign country)

Immediate cause of death: Apoplexy (abdominal type) Chronic myocarditis with dilatation

Due to _____

Due to _____

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER { 12. Name Mr. Mudge

FATHER { 13. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Mrs. Ada Sefert

(b) Address 3850 Nelson Drive

17. (a) Burial (b) Date thereof Nov. 15, 1943.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) NOV 15 1943 (b) E. B. McCarroll, M. D.
(Date received local final file) (Registrar's signature) 25.

Major findings: Of operations _____

Of autopsy _____ 96

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 2ED

(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 [Signature] (M. D. or other) _____
Address 4921 1/2 Eastern Ave (13) Date signed 11/13/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

John A. Melnar

Licensed Embalmer No.

4186

P. O. Address

Other m.

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.