

15-43
-17-39
X36671

FILED JAN 20 1944
378

1003

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:
BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 30 days (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME Callie Bane
 3. (b) If veteran, name war None
 3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Henry H. Bane
 6. (c) Age of husband or wife if alive 66 years
 7. Birth date of deceased June 17 1881
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 6 19 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Sam J. Bare

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

14. Maiden name Ida Caruthers

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

16. (a) Informant Verna Sanders

(b) Address Campbell, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-44
 (Month) (Day) (Year)

(c) Place: burial or cremation Campbell, Missouri

18. (a) Signature of funeral director Albert H. Hoppe, Inc.
 (b) Address 4700 Washington Blvd.

19. (a) JAN 6 1944 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 103
 (a) State Missouri (b) County Stoddard
 (c) City or town Bernie NR
 (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 January day 5th year 1944 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from December 7th, 1943, to January 5, 1944, that I last saw her alive on January 5, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis
Carcinomatous
Carcinoma of Ovary
Primary of Ovary
 Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: HA
 Of operations _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy not completed, as above.

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.C. Abner (M. D. or other) _____
 Address BARNES HOSPITAL Date signed 1/6/44

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

MOTHER FATHER

844

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..... *W. Wilkins*.....
Licensed Embalmer No..... *3575*.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 37
744Registrar's No. 744

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Barnes Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 days
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Callie Bane3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____4. Sex 7 5. Color or race w 6. (a) Single, widowed, married,
divorced _____6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased June 17
(Month) (Day) (Year)8. AGE: Years 62 Months 6 Days 6 (If less than one day, _____ min.)9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) MAR 20 1944 (b) J. F. Prelech
(Date received local registry) (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 June day _____
year 1944 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 sta-
tistically.

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

37