

S. No. 2  
OM-5-43  
v. 5-17-39  
1 X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5389

FILED MAR 1944  
318

State File No. \_\_\_\_\_  
Registrar's No. 1618

Registration District No. 318 Primary Registration District No. 1003

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

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:  
3140 Kimberly Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3140 Kimberly Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Theresa Catherine La Mola  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Michael La Mola  
6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased Sept. 6 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
58 5 10 hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Charles Peers  
13. Birthplace Nova Scotia  
(City, town, or county) (State or foreign country)  
14. Maiden name Hannah McCarthy  
15. Birthplace Canada  
(City, town, or county) (State or foreign country)

16. (a) Informant Michael La Mola  
(b) Address 3140 Kimberly Ave.  
17. (a) Burial (b) Date thereof 2-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem. Drehmann-Harral  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 1905 Union Blvd

19. (a) FEB 18 1944 (Date received local registrar)  
J. F. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16  
year 1944 hour 4 minute 05 P.M.  
21. I hereby certify that I attended the deceased from February 15th, 1944, to Feb. 16, 1944,  
that I last saw her alive on Feb. 16, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 days  
Due to Hypertension 6 mos.

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)  
Means of injury 0  
23. Signature [Signature] (M. D. of State)  
Address 508 N. Grand Blvd. Date signed Feb. 17, 44

metno Betty  
1 to 3 p.m.

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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.....

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

Signed Warren A. Carver

Licensed Embalmer No. 3534

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.**