S. No. 2
DM—2-43
S-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 20 1944

Registration District No. 379

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 19189

Registrar's No. 1080

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community one month

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis
(c) City or town Robertson (If outside city or town limits, write "RURAL")
(d) Street No. Route #1 Box 38 (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Margaret Viers
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Michael
6. (c) Age of husband or wife if alive D years
7. Birth date of deceased Jan (Month) 23 (Day) 1857 (Year)
8. AGE: Years 87 Months 3 Days 16 If less than one day ____ hr. ____ min.
9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Householder
11. Industry or business ____
FATHER 12. Name John Moss
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
MOTHER 14. Maiden name Barbara Vance
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)
16. (a) Informant Charles Viers
(b) Address Robertson Mo. R#1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-44 (Month) (Day) (Year)
(c) Place: burial or cremation Fee Fee Cemetery
18. (a) Signature of funeral director Baumann Bros., Inc.
(b) Address 2504 Woodson Rd-Overland
19. (a) MAY 12 1944 (Date received local registrar) (b) E. G. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 year 1944 hour 1+5 minute A M.
21. I hereby certify that I attended the deceased from 4/11/44, 19__, to 5/9/44, 19__; that I last saw her alive on 5/9, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
arteriosclerosis,	
arteriosclerotic heart disease	
Due to fractured r hip	1 mo
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy 186a 29

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) ACCIDENT
(b) Date of occurrence 4-11-44
(c) Where did injury occur? Robertson, Missouri (City or town) (County) (State) home (Specify type of place)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fell in back yard of her home.
While at work? no (e) Means of injury Frac. hip
23. Signature James A. Cornish (M. D. or other)
Address County Hospital Date signed 5-10-44

(Licensed Embalmer's Statement on Reverse Side)

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. G. Peterson

Licensed Embalmer No. #3767

P. O. Address Overland Mo

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.