

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JUN 10 1944

State File No. \_\_\_\_\_  
Registrar's No. 5302

Registration District No. 318 Primary Registration District No. 1005

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution 1106 S. Cardinal  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) 40 yrs

3. (a) PRINT FULL NAME MAGGIE HURT  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE race col 5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years about Months 70 1/2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Fuller Rock Ark  
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name not known  
13. Birthplace ll  
(City, town, or county) (State or foreign country)

FATHER { 14. Maiden name not known  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Maggie Premier

(b) Address 313 1/2 Hickory

17. (a) Quincy (b) Date thereof 6-12-44  
(Barrel, casket, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. W. Watson

(b) Address 2769 Chestnut  
JUN 12 1944 (c) J. F. Benedek  
(Date received local registrar) (Registrar's signature)

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. 1106 So Cardinal  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 7  
year 1944 hour 11 minute 45  
21. I hereby certify that I attended the deceased from 5-31, 1944, to 6-7, 1944;  
that I last saw her alive on 6-7-44  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Hypertension  
Due to 8 1/2  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 W. C. Dwyer (M. D. or other)  
Address 941 N. Seventh Date signed \_\_\_\_\_

**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.....

Licensed Embalmer No. *2698*

P. O. Address. *27690 Court*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**