V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23250

State File No.

FILED JUL 21 1944

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 6204

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: Homer Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 weeks (Specify whether
In this community Abt. 26 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County 17
(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")
(d) Street No. 4511 Aldine 11
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Sarah Maul
3. (b) If veteran, name war ----
3. (c) Social Security No. None
4. Sex Female
5. Color or race Negro 3
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Victor Maul
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Unavialable (Month) Abt. 1871 (Day) (Year)
8. AGE: Years Abt. 73 | Months | Days | If less than one day hr. min.
9. Birthplace Cadet (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation House-work at Home
11. Industry or business
FATHER
12. Name Mike Maul
13. Birthplace Cadet (City, town, or county) Missouri 0 (State or foreign country)
MOTHER
14. Maiden name Ellen Vaughn
15. Birthplace Cadet (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant William Maul
(b) Address 4306 West Belle Pl.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Kimswick, Missouri
18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Ave.
19. (a) JUL 12 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th
year 1944 hour 5:30 minute Pm M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Fractured Left Hip; arteriosclerosis; | Duration
Due to suffered when deceased fell to the floor at her
Due to home 4511 Aldine Ave on June 1st 1944 at about 12:00 noon.
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 186
Of autopsy 18

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 6-1-44 000
(c) Where did injury occur? St Louis Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? no (e) Means of injury Fall
23. Signature Thomas F. Callanan (M.D. or other)
Address 1300 Clark Ave. Date signed 7-11-44

(Licensed Embalmer's Statement on Reverse Side) Deputy Coroner

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 Charles J. Gates, Sr., Registered Apprentice No. ....., working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.