

S. No. 2
M-5-42
v. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26620

State File No.

FILED AUG 25 1944 318

Primary Registration District No. 1003

Registrar's No. 7145

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:
City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 2 Days
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME Alice Suter

3. (b) If veteran, name war.....

3. (c) Social Security No. Nons

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced, Widow

6. (b) Name of husband or wife..... James Valentine

6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased..... July 28th 1888
(Month) (Day) (Year)

8. AGE: Years Months Days 56 0 21 If less than one day hr. min.

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

10. Usual occupation..... Housework

11. Industry or business.....

MOTHER FATHER

12. Name..... John Valentine

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

14. Maiden name..... Not known

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

16. (a) Informant..... Mrs Grace Bertel

(b) Address..... 3235 N 20 Th Str 1944

17. (a) Burial (b) Date thereof..... Aug. 18th 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Calvary Cemetery

18. (a) Signature of funeral director..... Ed Koch

(b) Address..... 3516 N. 14 Th Str

19. (a) AUG 16 1944 (b) J. F. Bredbeck
(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. 3307 N. 20 Th Str
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15th
year..... 1944 hour..... 2 minute..... 45 P.M.

21. I hereby certify that I attended the deceased from 8/13/44
..... 19..... to..... Aug. 15th 1944
that I last saw h. er alive on..... Aug. 15th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death..... Cerebral hemorrhage
Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... none

Of autopsy..... refused

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)
(c) Means of injury.....

23. Signature..... Stu Thomas (M. D. or other)
Address..... 1515 Lafayette Date signed..... 8/16/44

2025 05 01 01:14

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 *Howard A. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *Theris 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.