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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

29391

State File No. ....

Registrar's No. 7947

Registration District No. .... Primary Registration District No. ....

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Barnes Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 days (Specify whether  
In this community 3 Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County 000  
(c) City or town St. Louis. (If outside city or town limits, write "RURAL") 17  
(d) Street No. 5142 Westminster Place. (If rural, give location) 912  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Mary Leocadie Hamel  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 15th  
year 1944 hour 5 minute - A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow.  
6. (b) Name of husband or wife Moise Hamel 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Oct. 15 (Month) (Day) 1865 (Year)

21. I hereby certify that I attended the deceased from September 14th 1944 to September 15th 1944; that I last saw her alive on September 15th 1944; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
78 11 0 hr. min.

Immediate cause of death Hypertensive cardiac vascular disease; myocardial infarction; Arterio-sclerotic heart disease; Nephrosclerosis; Pyelonephritis  
Due to Pyelonephritis

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

Due to.....  
Other conditions (include pregnancy within 3 months of death).....

10. Usual occupation At Home

Major findings: Of operations.....  
Of autopsy As above

11. Industry or business.....

MOTHER FATHER  
12. Name Unknown  
13. Birthplace " (City, town, or county) (State or foreign country) 9  
14. Maiden name " (City, town, or county) (State or foreign country) 9  
15. Birthplace " (City, town, or county) (State or foreign country) 9

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
131

16. (a) Informant John M. Batschy  
(b) Address 5142 Westminster Place

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?.....

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-44 (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly  
(b) Address 3840 Lindell Blvd.  
19. (a) SEP 16 1944 (Date received local registrar) (b) J. H. Hedges (Registrar's signature)

While at work (Specify type of place) (c) Means of injury.....  
23. Signature Huelsmann (M.D. or other)  
Address BARNES HOSPITAL Date signed 9-15-44

Huelsmann

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

**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 H Van Matres  
Licensed Embalmer No. 2825  
P. O. Address 4340 Lafayette

**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.**