

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 20 1944
818

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29900**
Registrar's No. **7888**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **ST. LOUIS MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St John Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days.**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3140 Halliday St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **11**
year **1944** hour **10 30** P.M. minute _____ M.

21. I hereby certify that I attended the deceased from **July 12**, 19**44**, to **Sept 11**, 19**44**,
that I last saw her alive on **Sept 11**, 19**44**,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial infarction

Due to **Coronary atherosclerosis**

Due to **Adeno-Carcinoma of St. Breast**

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

Major findings: Of operations _____
Of autopsy _____

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 _____ (M. D. or other)
Address **4907 Maryland** Date signed **9/13/44**

3. (a) PRINT FULL NAME **JOSEPHINE UHRICH**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Frank Ulrich** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Oct. 21 1895**
(Month) (Day) (Year)

8. AGE: Years **48** Months **10** Days **21** hr. _____ min. _____
If less than one day

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

10. Usual occupation **At Home**

11. Industry or business **Housewife.**

12. Name **Peter Vlader**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Frank Ulrich**
(b) Address **3140 Halliday St.**

17. (a) **Burial** (b) Date thereof **Sept 14/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New S. S. Peter & Paul**

18. (a) Signature of funeral director **Theodotis & Son**

(b) Address **2906 Gravois Ave.**

19. (a) **SEP 13 1944** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *David Lee Fossum*.....

Licensed Embalmer No. *4242*.....

P. O. Address *2906 Merrick*.....

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.