

S. No. 2
M-8-43
5-17-39
P-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

36094

State File No.

STANDARD CERTIFICATE OF DEATH

9825

Registrar's No.

FILED NOV 30 1944
Registration District No. 318

Primary Registration District No.

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:
5469 Oriole Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5469 Oriole Ave
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3. (a) PRINT

FULL NAME Ruth Ann Elyse La Flam

3. (b) If veteran,

name war.....

3. (c) Social Security

No.

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... June 9 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 5 10 ..hr. ..min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Chas La Flam
13. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)
14. Maiden name Ruth Marten
15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Chas La Flam

(b) Address 5469 Oriole

17. (a) Burial (b) Date thereof 11 21 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Calvin F. Feutz

(b) Address NOV 20 1944 4289 1/2 St. Bridge Blvd

19. (a) NOV 20 1944 (b) J. J. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19
year 1944 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from June 9, 1944
....., 19....., to November 19, 1944
that I last saw her alive on November 2, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hydrocephalus (Congenital) Duration

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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)
(e) Means of injury.....

23. Signature Robert E. Shea (M. D. or other)

Address 4991 Delwood Date signed 11/19/44

(Licensed Embalmer's Statement on Reverse Side)

Shea

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 John A. Menard
Licensed Embalmer No. 4186
P. O. Address St. Louis 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.