

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 7 1945

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

State File No. _____
Registrar's No. **818**

Registration District No. **318** Primary Registration District No. _____

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:
4948 Page 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 _____
years, months or days)

3. (a) PRINT FULL NAME **Bertha L. Atkinson**
3. (b) If veteran, name war **Nil**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Omer Atkinson**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **November 7 1872**
(Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **19**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **George W. Grigg**

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

14. Maiden name **Addie Belle**

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

16. (a) Informant **Mrs. Adele Wright**

(b) Address **4948 Page Ave.**

17. (a) **Burial** (b) Date thereof **1-29-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd**

19. (a) **JAN 26 1945** (b) **J. F. Brebeck**
(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. **4948 Page**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **26** year **1945** hour **12** minute **9** M.

21. I hereby certify that I attended the deceased from **27** 19 **45** to **Jan 26** 19 **45**
that I last saw her alive on **Jan 26 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchiectasis**
Due to **Arteriosclerosis**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____

Of autopsy **none**
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 **Harry H. Meyer** (M. D.)
Address **7903 Delmar** Date signed **1/26/45**

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

MOTHER FATHER

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 Ogowski
Licensed Embalmer No. 3398
P. O. Address.....

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.