

FILED JAN 16 1945

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Missouri 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.....
In this community..... 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No. 6438 Virginia Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mrs Mary Rose Iott

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22
year 1945 hour 2 minute 55 P.M.

21. I hereby certify that I attended the deceased from.....
19....., to..... 19.....;

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Thomas 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased April 2 1862
(Month) (Day) (Year)

that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture left shoulder
Arteriosclerosis, urticaria, tripped
over rug in the bedroom at her
home, and fell to the floor
Dec. 19, 1944, at about 12:00 noon

Due to.....
Due to.....

8. AGE: Years 82 Months 9 Days 0
If less than one day hr. min.

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

Major findings: Of operations.....

Of autopsy.....

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

10. Usual occupation Housewife

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

MOTHER FATHER { 12. Name John B Moussette

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

14. Maiden name Unkn

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Dec 19 1944

(c) Where did injury occur? St. Louis IND
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant Mrs. A. Vaughan

(b) Address 4936 Mardel

17. (a) Burial (b) Date thereof 1-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive Cemetery

23. Signature [Signature] (M. D. or other) fall
While at work (Specify type of place) (a) Means of injury

Address [Address] Date signed 1/2/45

18. (a) Signature of funeral director C. Hoffmeister, Col.
(b) Address 6464 Chippewa Ave Mortuary

19. (a) JAN 1 1945 J. F. Bredish
(Date received local registrar) (Registrar's signature)

Business Office

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 *Harry J. Schumacher*
..... Licensed Embalmer No. *2679*
..... P. O. Address *732 Lemay Ferry rd.*

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.