

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

633

FILED JAN 31 1945
318

Registration District No. _____

Primary Registration District No. _____

Registrar's 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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ days 10
(Specify whether _____)
In this community _____
years, months or days 15 yrs.

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. 3545 Grace Av.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mae Klene

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 Widowed
6. (b) Name of husband or wife Robert 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 10 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name Francis Ferguson
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Julia Angelo
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Hell M. Ferguson

(b) Address 3545 Grace Avenue

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1 22 45 (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (c) Signature of funeral director H. W. McLaughlin

(b) Address 8301 Lafayette Avenue

19. (a) JAN 22 1945 (Date received local registrar) (b) J. T. Brudek (Registrar's signature)

20. DATE OF DEATH: Month Jan. day 19th
year 1945 hour 2:00 minute P. M.

21. I hereby certify that I attended the deceased from 1/12/45, 19____, to 1/19/45, 19____; that I last saw him or alive on 1/19/45, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy same

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 Herbert C. Fritz (M. D. or other) 1/20/45
Address 1515 Lafayette Date signed _____

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 L R Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 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.