

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 31 1945
318

1003

Registration District No. _____ Primary Registration District No. _____

Registrar's No. 657

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(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 - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 days
(Specify whether 10)
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. 4219 Lexington Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bell Maher

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 Albert F. Maher
6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased May 16, 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>8</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Albert F. Maher

(b) Address 4219 Lexington Ave.

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

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge

19. (a) JAN 20 1945 (b) J. F. Breuck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19th
year 1945 hour 11:30 minute P. M.

21. I hereby certify that I attended the deceased from 12/25/44
, 19____, to 1/19/45, 19____;
that I last saw her alive on 1/19/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized arteriosclerosis

Due to _____
Due to _____

Other conditions Hypertrophic arthritis
(Include pregnancy within months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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)
(c) Means of injury _____

23. Signature E. W. Gelbreck (M. D. or N. D.)
1515 Lafayette Date signed 1/19/45

Address _____ Date signed _____

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed.....

Sheldon Collier

Licensed Embalmer No.

338 v

P. O. Address.....

4600 7th Blvd

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.