

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 7 1945
318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **9011**

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:
Lutheran Hospital
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Randolph**
(c) City or town **Prairie Du Rocher**
(If outside city or town limits, write "RURAL") **N.R.O.**
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mary Nevois**

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 **Unknown** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 18 1871**
(Month) (Day) (Year)

8. AGE: Years **73** Months **4** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Troy Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **James McClanahan**

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

14. Maiden name **Clementine De Fox**

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

16. (a) Informant **Arthur Stoeckel**

(b) Address **2711 Tennessee**

17. (c) **Removal** (b) Date thereof **1-30-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Red Bud, Illinois**

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

(b) Address **4700 Washington Blvd.**

19. (a) **JAN 29 1945** (b) **J. F. Budick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **29**
year **1945** hour **6:08** minute **A.** M.

21. I hereby certify that I attended the deceased from _____, 1940 to **Jan 22**, 1945
that I last saw her alive on **Jan 29**, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Ch hepatitis
Ch myocarditis

Due to **Hypertension**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **1/31**

Major findings:
Of operations _____
Of autopsy _____

Duration

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 **R. Berg** (M. D. or other) **md**
Address **2253 Nevada** Date signed **1/29/45**

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 *Albert G. Happe*

Licensed Embalmer No. *2991*

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.