

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 5 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

4561

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1578

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ST. JOHN'S
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days) 0 (Specify whether

3. (a) PRINT
FULL NAMEMAHER, EMMA

3. (b) If veteran,

name war _____

3. (c) Social Security

No. 497-16-7054

4. Sex FEM. 1 5. Color or
 race W. 6. (a) Single, widowed, married,
2 divorced WID.

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

7. Birth date of deceased APRIL 10, 1886
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 10 6 hr. min.

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

10. Usual occupation SEAMSTRESS

11. Industry or business _____

12. Name CHARLES GAGNER

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

14. Maiden name MARY BAUCIER
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Agnes Gagner
 (b) Address 1022 Broadview

17. (a) BURIAL (b) Date thereof FEB. 19-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.18. (a) Signature of funeral director M. J. CROGHAN(b) Address 716 MANCHESTER19. (a) FEB 18 1945 (b) J. T. Thebeck

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1022 GRANDVIEW PL.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 16
 year 1945 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from October
20, 1945, to Feb 16, 1945

that I last saw h. a alive on Feb. 15, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

Acute Dilatation of Heart

Due to Vascular Heart Disease Eyes
with Cerebral Thrombosis 4 mos

Due to _____

Other conditions gangrene of L. foot 2 mo.
 (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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 523. Signature Michael Dulick (M. D. or other)Address 2319 Brentwood Blvd. Date signed 2-17-45

(Licensed Embalmer's Statement on Reverse Side)

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

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 P. Hoppa

Licensed Embalmer No.

2971

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.