

S. No. 2
OM-2-43
v. 5-17-39
X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4711

State File No. _____

FILED MAR 14 1945

1003

Registrar's No. 2006

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Deaconess Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Maplewood 9th
(If outside city or town limits, write "RURAL")

(d) Street No. 2207 Alameda St NR
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mrs Marie Powers

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27th
year 1945 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from September 25, 1944 to Feb 27, 1945,
that I last saw h. ev alive on Feb 26, 1945,
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John Powers 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased December 21 1890
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage (right hemisphere) Duration 3 wks

Due to Hypertensive Heart Disease yrs. _____

Due to Nephritis yrs. _____

Other conditions (include pregnancy within 3 months of death) Diabetes (controlled)

8. AGE: Years 54 Months 2 Days 6 If less than one day _____
hr. min.

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

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife

11. Industry or business _____

12. Name Paul Creely

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

14. Maiden name Jenna Auerbach

15. Birthplace Floerssant Mo
(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) _____

(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 _____

16. (a) Informant John Powers

(b) Address 2207 Alameda

17. (a) burial (b) Date thereof 3-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ferdinand Cem.

18. (a) Signature of funeral director M. J. Coughlin

(b) Address 7146 Manchester

19. (a) MAR 1 1945 J. P. Redek
(Date received local registrar) (Registrar's signature)

23. Signature: Blair W. Westrup (M. D. or other) M. J. Coughlin
Address 201 E. Big Bend Wabasha Date signed 3-1-45

(Licensed Embalmer's Statement on Reverse Side)

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

1979

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. *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.

Slav: 1971