

V. S. No. 2
 00M-5-43
 Rev. 5-17-39
 I X34671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

7984
 2690
 State File No. _____
 Registrar's No. _____

FILED APR. 8 1945

1003

Registration District No. _____

Primary Registration District No. _____

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:
Josephine Heitkamp Hospital (1)
 (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 Missouri (b) County St. Louis
 (c) City or town Richmond Heights 91 NR
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7570 Warner Ave
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Harriet McGaughey

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John E. McGaughey 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased 11/10/1877
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 4 13 hr. min.

9. Birthplace Blue Mound Ill
 (City, town, or county) (State or foreign country)

10. Usual occupation At. Home

11. Industry or business _____

12. Name Levi Showalter

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

14. Maiden name Augusta Walz

15. Birthplace U.S.A.
 (City, town, or county) (State or foreign country)

16. (a) Informant John E. McGaughey

(b) Address 7570 Warner Ave

17. (a) Removal (b) Date thereof 3/21/45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Butler Mo

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) MAR 25 1945 J. F. Bredbeck
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
 year 1945 hour 5.32 minute _____ A. M.

21. I hereby certify that I attended the deceased from January 20 27 to 3/23/45, 19____
 that I last saw her alive on 3/22/45, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death
 (1) Cerebral Hemorrhage 2 days
arterial sclerosis + cardiac
thrombosis Hypertension
 Due to _____
 (2) Diabetes mellitus 2 yrs
 Due to _____
 (3) Partial Intestinal obstruction 7 days
due to chronic cholelithiasis
 Other conditions _____
 (Include pregnancy within 3 months of death)

Duration
2 days
2 yrs
7 days

Major findings:
 Of operations _____

(1) (2) (3) found in
autopsy
 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? _____

Which at work? _____ (Specify type of place)
 (b) Means of injury _____
 Signature H. Gustave Schmitz (M. D. or other)
 Address 1152 South Grand Ave Date signed 3/23/45

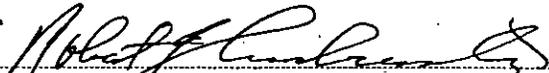
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 

Licensed Embalmer No. 1994

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.