S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1945

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 8027

Registrar's No. 2752

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: St. John's Hospital 6
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town O'Fallon 92
(If outside city or town limits, write "RURAL")

(d) Street No. 0 N.R.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Alvina Merz

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife William Merz

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased March (Month) 10 (Day) 1903 (Year)

8. AGE:

Years	Months	Days	If less than one day
42	0	16	hr. min.

9. Birthplace O'Fallon (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Frank Hemmer
13. Birthplace O'Fallon (City, town, or county) Missouri (State or foreign country) 1

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant William Merz
(b) Address O'Fallon, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Dardenne, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAR 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1945 hour 11:55 minute P. M.

21. I hereby certify that I attended the deceased from 3-21, 1945, to 3-26, 1945 that I last saw her alive on 3-26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial insufficiency, Arterio-sclerotic heart dis. — Duration: 2 weeks

Due to

Due to

Other conditions none 93
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

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) no

(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? — (Specify type of place)

While at work? — (e) Means of injury —

23. Signature J. H. Hammond (M. D. or other) M.D.

Address 6134 N. Grand Date signed 3/27/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.