

S. No. 2
M-5-43
7-5-17-39
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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. **8166**
Registrar's No. **2537**

FILED MAR 28 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital #1.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1111 N. 12th St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Owen Richards**
3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **Unknown**
4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife **Victoria Richards**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **September 5 1863**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **16th**
year **1945** hour **10:45** minute **P.** M.
21. I hereby certify that I attended the deceased from **3/7/45**
to **3/16/45**, 19____, to **3/16/45**, 19____;
that I last saw him alive on **3/16/45**, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death **Myocardial failure** Duration _____

8. AGE: Years Months Days If less than one day
81 6 11 hr. min.

Due to **Arteriosclerotic heart disease**

9. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)
10. Usual occupation **Laborer**

Other conditions **Benign hypertrophy of prostate**
(Include pregnancy within 3 months of death)

11. Industry or business _____
MOTHER FATHER { 12. Name **Unknown**
13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Unknown**
(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.

16. (a) Informant **Frank Gorham**
(b) Address **3933 N. 25th St.**
17. (a) **Burial** (b) Date thereof **3-19-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

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 _____

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**
19. (a) **MAR 20 1945** (b) **J. F. Bradeck**
(Date received) (Registrar's signature)

23. Signature **H. King Madsen** (M. D. or other)
Address **1515 Lafayette** Date signed **3/17/45**

(Licensed Embalmer's Statement on Reverse Side)

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

2537

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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 *John Ogroski*
Licensed Embalmer No. *2398*
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.