. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 26 1945

Registration District No. 377

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3069

State File No. 10713

Registrar's No. 668

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's 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 Missouri (b) County St. Louis

(c) City or town Brentwood
(If outside city or town limits, write "RURAL")

(d) Street No. 8515 Genevieve Ave.
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME WARD - KATHLEEN

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

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

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

7. Birth date of deceased November (Month) 30 (Day) 1944 (Year)

8. AGE: Years | Months 3 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Milwaukee (City, town, or county) Wisconsin (State or foreign country)

10. Usual occupation Infant

11. Industry or business .....

FATHER
12. Name Charles Ward
13. Birthplace Granite City (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Marie Bayer
15. Birthplace Elwood (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Betty Tiefunbrun
(b) Address 8515 Genevieve Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-12-45 (Month) (Day) (Year)
(c) Place: burial or cremation Edwardsville, Ill.

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

19. (a) MAR 13 1945 (Date received local registrar) (b) E. G. McCauran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 12 year 1945 hour 5 minute 37 A.M.

21. I hereby certify that I attended the deceased from 1-25 ....., 1945, to 3-12, 1945 that I last saw him alive on 3-11, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory failure	3-12-45
Due to: Marasmus	
Due to: Gastro enteric indigestion	1-25-45
Other conditions: "Celiac Disease" (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? ..... (Specify type of place)

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

23. Signature [signature] (M. D. or ~~[illegible]~~)

Address 634 N. Grand Date signed 3-12-45

(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. 1861

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.