

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 2207774
3957
Registrar's No. 3957

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Christian Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community 72 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 99

(d) Street No. 4518 Pope Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Catherine Hassett

3. (b) If veteran, name war none

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 William Hassett

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased June 2nd, 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>10</u>	<u>29</u>	hr. _____ min.

9. Birthplace St. Louis County 0
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Jacob Ochs

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gladys Scanlon

(b) Address 4518 Pope Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 5-4-45
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) MAY 4 1945
(Date received local registrar)

J. F. Brudick
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st.
year 1945 hour 6:30 PM minute _____ M.

21. I hereby certify that I attended the deceased from 12-26-41
_____, 19____, to May 1 - 1945;
that I last saw her alive on May 1 - 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to Hypertension

Due to _____

Other conditions g d
(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. Phyllis (M. D. _____)

Address 607 N. Grand St. Date signed 5-7-45

Dr. Rymer -
Missouri -
@ June 1919

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 P. Buchholz*

Licensed Embalmer No. *1674*

P. O. Address *2223 St. Louis Ave*

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.