No. 2
I—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 1945

Registration District No. 2

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 18289

Registrar's No. 1015

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 5300 Kirkland Dr.
(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 St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4622 Natural Bridge
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Elizabeth Toth

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female

5. Color or race White

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

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

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

7. Birth date of deceased November (Month) 2 (Day) 1886 (Year)

8. AGE: Years 59 Months 5 Days 22 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name John Rudnay
13. Birthplace ..... (City, town, or county) Hungary (State or foreign country)

MOTHER
14. Maiden name Marian Koss
15. Birthplace ..... (City, town, or county) Hungary (State or foreign country)

16. (a) Informant Frank Toth
(b) Address 5300 Kirkland Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Ave.

19. (a) MAY 2 1945 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24 year 1945 hour 11 minute 50 A M.

21. I hereby certify that I attended the deceased from Mar 1, 1945, to April 24, 1945 that I last saw her alive on April 24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac decompensation	6 yrs
Due to Myocarditis, chr.	
Due to Arterial hypertension	
Other conditions none (Include pregnancy within 3 months of death)	93 d
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) ✓

(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 C. E. Gilliland (M. D. or other) MD

Address 7124 Nat. Br. Date signed 4/25/45

(Licensed Embalmer's Statement on Reverse Side)

JUN 2 1945

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 H. G. Faus

Licensed Embalmer No. 3384

P. O. Address St Louis

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.

S. No. 2B
M—3-45
No I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
5300 Kirkland Dr.
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ~~St. Louis~~

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

(d) Street No. 4622 Natural Bridge
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Toth, Elizabeth

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 59 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Stroot-Carroll Bridge

(b) Address 4600 Natural Bridge

19. (a) (Date received local registrar) (b) Dr. E. G. McNamara (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 Day 22 Year 1945 Hour Minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Cardiac decompensation

Due to arterial hypertension

Due to

Other conditions
(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 C. E. Alliland MD (M. D. or other)

Address 7124 Natural Bridge Date signed

SUPPLEMENTARY

18289