

REC JUN 30 1945

318

Primary Registration District No.

1003

Registrar's No. 5415 ✓

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:
Missouri Baptist 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: 000

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

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

(d) Street No. 4536a Wichita Ave.
(If rural, give location)

(e) Citizen of foreign country?..... 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mary Oma Josephine Agger

3. (b) If veteran, name war No.

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20
year 1945 hour 12 minute 30 A. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Walter 6. (c) Age of husband or wife if 2 years

7. Birth date of deceased: February 11, 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 12, 1945 to June 20, 1945
that I last saw her alive on June 19, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 4 Days 19
If less than one day hr. min.

Immediate cause of death: Topic thyroid which was operated on 6/18/45

Due to.....

Due to.....

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

Other conditions (Include pregnancy within 3 months of death).....

Major findings: Of operations.....

Of autopsy No autopsy

10. Usual occupation Domestic

11. Industry or business St. John's Hospital

12. Name Wm. E. Parson

13. Birthplace Fredericktown, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Jane Berry

15. Birthplace Fredericktown, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. E. Stogsdill
(b) Address 4536a Wichita Avenue

17. (a) Burial (b) Date thereof 6/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Gilead, Fredericktown, Mo.

18. (a) Signature of funeral director Rob't. J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

JUN 21 1945 (c) J. F. Brueck (Registrar's signature)

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?..... (Specify type of place)

(Specify means of injury) Means of injury.....

23. Signature O. E. Williamson (M. D. or Other)

Address 6336 Clayton Rd. Date signed 6/20/45

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

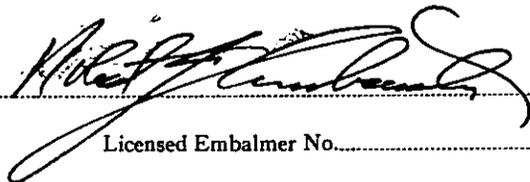
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JUN 21 1945

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



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.