

S. No. 2  
M-5-43  
7: 5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18557**

**JUN 30 1945**  
Registration District No. **1858**

Primary Registration District No. **1003**

Registrar's No. **5381**

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

**1. PLACE OF DEATH:**

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution:  
Deaconess 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 000

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

(d) Street No. 4216 Hereford St.  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Hazel P. Black

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 Single

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

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

7. Birth date of deceased April 1 1895  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>50</u>	<u>2</u>	<u>16</u>	_____ hr. _____ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Famous Barr Co.

12. Name Otto R. Black

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

14. Maiden name Margaret Figg

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

16. (a) Informant Sara I. Black

(b) Address 4216 Hereford St.

17. (a) Burial (b) Date thereof 6 20 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Kriegshauser Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) JUN 19 1945 (Date received local registrar)  
J. F. Greider (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 17 year 1945 hour 3 minute 45 A. M.

21. I hereby certify that I attended the deceased from January 1945 to June 17 1945  
that I last saw her alive on June 17 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death congestive heart failure Duration 3 days

Due to Mitral stenosis  
chronic valvular heart disease

Due to \_\_\_\_\_

Other conditions none  
(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? \_\_\_\_\_

23. While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_

Signature Blair & Roots (M. D. or other) MD.  
Address 3723 S. Kingshighway Date signed 6-18-45

Dr. L. E. Hosto  
3723a So. Kingshighway

7/16/00

**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 *Richard W. Storzano*

Licensed Embalmer No. *4007*

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.**