

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

37002
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 19281

FILED JUN 30 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5165

1. PLACE OF DEATH:

(a) County _____

(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:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos - 27 days
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME LYDIA THROCKMORTON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William S. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 18 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>2</u>	<u>23</u>	hr. _____ min. _____

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

10. Usual occupation Home

11. Industry or business C. P. Smith

12. Name C. P. Smith

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

14. Maiden name Martha Rutan

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

16. (a) Informant Gertrude Richardson

(b) Address 3618 McDonald Ave.

17. (a) Burial (b) Date thereof June 12, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director Wacker Alderfer
3634 Gravois Ave

(b) Address _____

19. (a) JUN 17 1945 (Date received local registrar) J. F. Bredenk (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 3618 McDonald Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11th
year 1945 hour 9:05 minute A M.

21. I hereby certify that I attended the deceased from 3/14/45
_____, 19____, to 6/11/45, 19____;
that I last saw her alive on 6/11/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Senility

Due to _____

Other conditions 162
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

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)

(c) Means of injury _____

23. Signature Kans B. Mollath (M. D. or other) MD
1515 Lafayette 6/11/45
Address _____ Date _____

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

JUL 5 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.

JUL 11 1945

Signed Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Shawmut

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.