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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21184

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1083

1. PLACE OF DEATH:

(a) County St. Louis,

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

(c) Name of hospital or institution:
Shamrock Nursing Home, 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 006

(a) State Missouri (b) County 17

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

(d) Street No. 5733 Vernon Ave.,
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Susan Compton,

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 3

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife James M. Compton,

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

7. Birth date of deceased February 8, 1866,
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
79	2	29	hr. min.

9. Birthplace Palmer, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife,

11. Industry or business

FATHER
12. Name George Scott,
13. Birthplace Missouri, 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jas. M. Smith,
(b) Address 6810 Crest Ave.,

17. (a) burial (b) Date thereof 5/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Lindell Blvd.

19. (a) MAY 9 1945 (b) E. C. McLauren MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1945 hour one minute 40 P.M.

21. I hereby certify that I attended the deceased from Mar. 13, 1944, to May 7, 1945
that I last saw her alive on May 7, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic pneumonia	2 days
Due to Hemiplegia 8/3	14 mo.
Due to Arteriosclerosis	10 yrs
Other conditions Fracture of right femur (Include pregnancy within 3 months of death)	11-30-44

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0

23. Signature E. H. Johnson (M. D. or other) MD
Address 2435 N. Grand Date signed 5-8-45

(Licensed Embalmer's Statement on Reverse Side)

E Horace Johnson
2431 N Grand Ave.

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 Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4005 Lexington

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 21184

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1083

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
(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 (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Susan Compton

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. 8 (Month) 1866 (Day) (Year)

8. AGE: Years 79 Months 2 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) MO (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

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 7
year 1945 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from March 13, 1944 to May 7, 1945
that I last saw h[illegible] alive on May 7, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	3 days?
Due to Confinement in bed?	
Due to Fracture of neck of right femur	5½ mo.
Other conditions (Include pregnancy within 3 months of death) Fracture of right hip 11/30/44	
Major findings: Of operations Impacted fracture of neck of right femur?	
Of autopsy 1860	

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 Nov. 30, 1944

(c) Where did injury occur? Her home 5355 Vernon Av St Louis (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home - residence (Specify type of place)

While at work? no (e) Means of injury Fall

23. Signature E H Johnson (M. D. Brother)

Address 2455 N. Grand Av Date signed 7/12/45

SUPPLEMENTARY