

U.S. No. 2
FORM-5-43
Rev. 5-17-39
1 X36671

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. **21260**
Registrar's No. **1252**

Registration District No. **317** Primary Registration District No. **3066**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Kirkwood**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rout 13 Box 568
(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 **Mo.** (b) County **St. Louis**
(c) City or town **Kirkwood** **96**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rt. 13 Box 568** **4**
(If rural, give location) **3**
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Helen L. Hite**
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 **Widowed**
6. (b) Name of husband or wife **William Hite**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Mar. 5 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 2 24 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business
12. Name **Adam Miller**
13. Birthplace **Scotland**
(City, town, or county) (State or foreign country)
14. Maiden name **Agnes Groves**
15. Birthplace **Scotland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mabel Amrein**
(b) Address **Kirkwood Mo.**
17. (a) **Burial** (b) Date thereof **5-31-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bellefontaine**

18. (a) Signature of funeral director **Drehmann-Harral**
(b) Address **1905 Union Blvd.**
19. (a) **JUN 1 1945** (b) **E. B. McParlan**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **29**
year **1945** hour **7** minute **40** A. M.
21. I hereby certify that I attended the deceased from **July 1** 19**44** to **May 29** 19**45**
that I last saw her alive on **May 29 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** **3 yrs**
Due to _____ **93d**
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **E. B. Barnett** (M. D. or other)
Address **243 W. Jefferson** Date signed **5/29-45**

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

MOTHER FATHER

Dr. C. E. Darnette, (K1. 944)
243 W. Jefferson

2 to 4

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 *Warren A. Carver*

Licensed Embalmer No. *3534*

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.