

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21490
Registrar's No. 1153

FILED JUN 19 1945
Registration District No. 377

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Miller Nurseing Home
(If not in hospital or institution, write street number or location)

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

In this community _____ years, months or days

3. (a) PRINT FULL NAME Emily Cathrine Statler

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female / 5. Color of race White

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

6. (b) Name of husband or wife David

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

7. Birth date of deceased June 15 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>11</u>	<u>3</u>	hr. min.

9. Birthplace Bo llinger County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Cornelus Limbagh

13. Birthplace Bollinger Countyri Missouri
(State or foreign country)

14. Maiden name Mary Smith
-15- Birthplace Bollinger County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Silas Statler

(b) Address 4639 Dahlia

17. (a) Burial (b) Date thereof 6/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewickville, Mo.

18. (a) Signature of funeral director W. M. Laughlin
(b) Address 2301 Lafayette

19. (a) WAY 21 1945 (b) E. G. Barron
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 8149 Gravois
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1945 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan. 45 to May 19 1945
that I last saw her alive on May 18 1945
and that death occurred on the date and hour stated above.

Immediate cause of death ac myocarditis
930

Due to _____

Due to _____

Other conditions Ch nephritis and Ch arterio sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration 4da

PHYSICIAN 6 mo 6 mo

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 B. A. Walters (S. D. or other) MD
Address 3608 S. Grand Date signed 5/19/45

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 L. P. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 115 B

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town 8149 Harris Boulevard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Miller Nursing Home
(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

3. (a) PRINT FULL NAME Emily C. Statter

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 June 16 1886
(Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-16-45 (b) E. J. ... M.D.
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

21400