. S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 28 1945

State File No. 21631

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6230

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(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 0 (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

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

(d) Street No. 1522 Salisbury St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Minnie Armes

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife William Armes

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Feby. (Month) 9th. (Day) 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
76	5	8	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Lemuel Hargrave
13. Birthplace (City, town, or county) Va. (State or foreign country)

MOTHER
14. Maiden name Emnalia Morrison
15. Birthplace (City, town, or county) Ohio (State or foreign country)

16. (a) Informant William Armes
(b) Address 1522 Salisbury St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand Bl.

19. (a) JUL 18 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th.
year 1945 hour 8.25 minute A. M.

21. I hereby certify that I attended the deceased from July 13, 1945 to July 17, 1945
that I last saw her alive on July 17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Complete heart failure	2 hrs
Due to Chronic Myocarditis + Hypertension.	4 Rs.
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 2202 [illegible] St. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Earl E Provost

Licensed Embalmer No. 1578

P. O. Address 3710 N. Grand Blv

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.