

FILED AUG 3 1945 STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **10003**

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: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Barbara Creighton

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 Married

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased 8-14-1914
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	11	16	hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name Christ Mueller

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant William Creighton

(b) Address 3522a N. 22nd St.

17. (a) Burial (b) Date thereof Aug. 1, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Wacker Beldorle

(b) Address 3634 Gravois Ave.

19. (a) JUL 31 1945 (b) Registrar's signature J. F. Bredenk
(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. 3520^{N.} 22nd Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1945 hour 12 minute 50 A. M.

21. I hereby certify that I attended the deceased from 7-27-45 to 7-29-45

that I last saw him alive on 7-29 and that death occurred on the date and hour stated above.

Immediate cause of death Edema of Brain

Due to _____

Due to _____

Other conditions Gall Stone - Kidney Stone
(Include pregnancy within 3 months of death)

Major findings: 7-27-45
Adrenalectomy (Left)

Of operations Inguinal

Of autopsy Abroad

Duration

2 days

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)

23. Signature J. F. Bredenk (M. D. or other) _____

Address 4065 So. Bruce Date signed 7-30-45

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..... *Frank J. Gland*
Licensed Embalmer No. *2675*
P.O. Address..... *W. South Me*

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.