

31776
S. No. 2
FORM-2-43
Rev. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21939**

FILED AUG 3 1945
Registration District No. **318**

Primary Registration District No. **1003** Registrar's No. **6464**

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

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**

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

(c) Name of hospital or institution: **City Hospital**
Max G. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 days**
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **17 22**

(d) Street No. **1229 S. 7th** **9**
(If rural, give location)

(e) Citizen of foreign country? **No** **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SHERRY GARNER**

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 **Single**

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

7. Birth date of deceased **May 29 1945**
(Month) (Day) (Year)

8. AGE: Years _____ Months **25** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **J. C. Garner**

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

14. Maiden name **Virginia Station**

15. Birthplace **920**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. C. Garner**
(b) Address **Director, Mo**

17. (a) **Remove** (b) Date thereof **7-25-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Director, Mo**

18. (a) Signature of informant **Sherrill Taylor**
(b) Address **Director, Mo**

19. (a) **JUL 25 1945** **J. F. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
year **1945** hour **11:55** minute **A** M.

21. I hereby certify that I attended the deceased from **July 19 1945** to **July 24, 1945**
that I last saw her alive on **July 24, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **B. coli sepsis** Duration _____

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 **Gilbert B. Laska** (M. D. or other) _____
Address **1525 Lafayette Avenue** Date signed **7/25/45**

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 *John DeGroschi*

Licensed Embalmer No.

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.