

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6159

FILED JUL 28 1945

Primary Registration District No. 1003

Registrar's No.

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:
5865 Maple Ave.
(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 Missouri (b) County 000
(c) City or town St. Louis 175
(If outside city or town limits, write "RURAL")
(d) Street No. 5865 Maple Ave. 4
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Grace McMahan Beene Misner

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fred Misner 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased July 20 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 11 25 hr. min.

9. Birthplace Paul Valley Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William McMahan

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

14. Maiden name Caroline Hamstrong

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

16. (a) Informant John L. Hoppe

(b) Address 105 S. 9th St.

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

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) Jul 16 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1945 hour 11:00 minute A. M.

21. I hereby certify that I attended the deceased from 9-25-45 1945, to 7-15 1945
that I last saw her alive on 7-15 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension

Due to Arteriosclerosis Cerebral
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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 J. F. Bredeck (M. D. or other)
Address 5899 Delmar Date signed 7-16-45

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

26
19
9

MOTHER FATHER

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 W. Wilkin

Licensed Embalmer No. 3575

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.