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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 28 1945

State File No. 22611

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 6310

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community 8 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1913 LaSalle Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MALINDA STEPHENS

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F.

5. Color or race W.

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

6. (b) Name of husband or wife John Stephens

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

7. Birth date of deceased Nov. 24 (Month) (Day) ~~1865~~ 1856 (Year)

8. AGE: Years 88 Months 7 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Logann
13. Birthplace Un Known (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Fannie Sheltom
15. Birthplace (City, town, or county) Virginia (State or foreign country)

16. (a) Informant Onie May Thompson
(b) Address 1913 Lasalle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (Month) (Day) (Year)
(c) Place: burial or cremation Bismark, Mo.

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

19. (a) JUL 21 1945 (Date received local registrar) (b) J. Z. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1945 hour 3:45 minute A M.

21. I hereby certify that I attended the deceased from July 13, 1945 to July 20, 1945 that I last saw her alive on July 20, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage from Ventricular septal artery due to Hypertension

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Herbert C. Fritz (M. D. or other)
Address 1515 Lafayette Avenue Date signed 7/20/45

(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.....

Licensed Embalmer No. 3633

P. O. Address 2307 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.