. S. No. 2
00M—2-43
ev. 5-17-39
X35697

WRITE 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

24278

FILED AUG 14 1945

State File No. 3

Registration District No. 1 6 Primary Registration District No. 5595 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Imperial, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Residence; R.R. # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 1 yr
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Jefferson

(c) City or town Kimmswick,
(If outside city or town limits, write "RURAL")

(d) Street No. R R. #2.
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ALDA VICTORIA OZORIO.

3. (b) If veteran, name war none.

3. (c) Social Security No. none.

4. Sex Female.

5. Color or race White.

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 June 18, 1887.
(Month) (Day) (Year)

8. AGE: Years 58. Months 0. Days 15. If less than one day hr. min.

9. Birthplace Alamosa, Calif.,
(City, town, or county) (State or foreign country)

10. Usual occupation House Mother at

11. Industry or business Washington University.

FATHER
12. Name Luiz de Tavares Ozorio.
13. Birthplace England.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Marianne Simpson.
15. Birthplace England.
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Porter.
(b) Address Kimmswick, Missouri.

17. (a) Removal. (b) Date thereof 7/6/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Farmington, Mo.,

18. (a) Signature of funeral director C.R.Lupton & Sons.
(b) Address 7233 Delmar Blv'd.,

19. (a) 7/5/45 (b) [signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3rd, year 1945. hour 7:00 minute P. M.

21. I hereby certify that I attended the deceased from Jan 2 1937 to July 3 1945 that I last saw her alive on June 19 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure Rt C. Mitral Stenosis

Due to Fibrosis of Lung

Due to Chr Heart Failure

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

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) no

(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 James R Wade MD (M. D. or other)

Address 1004 Mo Theatre Bldg Date signed 7/5/45

1266

(Licensed Embalmer's Statement on Reverse Side)

JUL 29 1946

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 8-13-45

Dr J. P. Wade.
Mo. Theatre Bld'g,
JE: 8620.
Hrs 1 - 4.
Res: 17 Crestwood Dr.
CA: 0376.

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 J. D. Lupton

Licensed Embalmer No. 2122.

P. O. Address St. Louis, Mo.

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.