

S. No. 2
FORM-5-43
REV. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED SEP 21 1945 STANDARD CERTIFICATE OF DEATH

State File No. 29079
7962
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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:
1414 S. Theresa 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 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 005
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 1414 S. Theresa (If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Margaret J. Hartman
3. (b) If veteran, name war no 3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 9th
year 1945 hour 1 minute _____ P. M.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife August 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased: Jan. 26, 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 1st 1945 to Sept 9th 1945
that I last saw her alive on Sept 9th 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months 7 Days 14 If less than one day _____ hr. _____ min.

Immediate cause of death: Pulmonary edema following hypertensive vascular disease
Due to _____
Due to _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation Housewife

Other conditions: _____
(Include pregnancy within 3 months of death)

11. Industry or business self
12. Name Andrew Brennan
13. Birthplace Ireland (City, town, or county) _____ (State or foreign country)
14. Maiden name Mary Shal
15. Birthplace Ireland (City, town, or county) _____ (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy _____

16. (a) Informant Miss Ida Brennan
(b) Address 1414 S. Theresa
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12, 1945
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary

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? _____

18. (a) Signature of funeral director Joseph A. Howard
(b) Address 1619 S. Grand
19. SEP 11 1945 (Date received local registrar) (b) J. Medel (Registrar's signature)

While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature J. Medel (M. D. or other) 24.5
Address 506 Olive Date signed 9/10/45

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..... *W Wilkins*
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.