

S. No. 2
 OM-5-43
 Rev. 5-17-39
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UNITED STATES DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **31812**
 Registrar's No. **9170**

FILED NOV 31 1945
 Registration District No. _____ Primary Registration District No. **1003**

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

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:
Josephine Heitkamp Hospital.
(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

3. (a) PRINT FULL NAME **Helen B. DePew.**
 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 _____
 6. (b) Name of husband or wife **Dr. Heber B. DePew.** 6. (c) Age of husband or wife if alive **66** years
 7. Birth date of deceased **November 19, 1892**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 11 3 .hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Edward Dowd.**
 13. Birthplace **Ireland.** (City, town, or county) (State or foreign country)
 14. Maiden name **Mary O'Leary.**
 15. Birthplace **St. Louis, Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Dr. H. B. DePew**
 (b) Address **26 Broadview Drive.**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-25-45** (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **Arthur Donnelly**
 (b) Address **3840 Lindell Blvd.**
 19. (a) **OCT 24 1945** **J. F. Bredrek** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
 (c) City or town **Clayton**
(If outside city or town limits, write "RURAL")
 (d) Street No. **26 Broadview Drive.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **27** day **October**
 year **1945** hour **6:00** minute **A.** M.
 21. I hereby certify that I attended the deceased from **July 18**, 19**45** to **October 22, 1945**
 that I last saw her alive on **October 21**, 19**45**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinomatous**
carcinoma of right ovary
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations **AAA**
 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. Bredrek** (M. D. or other) **M.D.**
 Address **515 N. Grand** Date signed **10/24/45**

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 *Stanley Marshall*.....

Licensed Embalmer No. *2868*.....

P. O. Address *3840 Russell*.....

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.