V. S. No. 2
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Rev. 5-17-39
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#50955

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35024

FILED DEC 12 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1054

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

1. PLACE OF DEATH:

(a) County

(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 St. Louis 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 5 days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

Street No. 2435a McNair Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARGARET BAKER

3. (b) If veteran, name war Mo

3. (c) Social Security No. None

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife William A.

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased February (Month) 9 (Day) 1893 (Year)

8. AGE: Years 52 Months 9 Days 24 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER

12. Name Charles Asinger

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Anna Collins

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

16. (a) Informant William A Baker

(b) Address 2435a McNair Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 6 45 (Month) (Day) (Year)

(c) Place: burial or cremation St Matthews Cemetery

18. (a) Signature of funeral director A W McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) DEC 1 1945 (Date received local registrar) (b) J. J. Breuck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 3rd year 1945 hour 3:50 minute P. M.

21. I hereby certify that I attended the deceased from 11/28/45, 19..., to 12/3/45, 19...; that I last saw her alive on 12/3/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Chronic Glomerulonephritis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None permitted

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 W H Hamilton (M. D. or other) MD

Address 1515 Lafayette Date signed 12/3/45

(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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 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.