DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35368

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10180

1. PLACE OF DEATH:

(a) County ~~Depaul Hospital~~

(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: DePaul 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 000

(c) City or town St. Louis, 7 6
(If outside city or town limits, write "RURAL")

(d) Street No. 5357 Lotus
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Frances Hatcher

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F. 1

5. Color or race White

6. (a) Single, widowed, married, divorced 2 Widow

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

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

7. Birth date of deceased Sept. 7, 1880 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	2	17	..... hr. ..... min.

Birthplace St. Louis, Mo. 0
(City, town, or county) (State or foreign country)

Usual occupation Housewife

Industry or business .....

12. Name Joseph Craden

13. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Frances (Unknown) 0

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

(a) Informant Mrs. Virginia Shannon

(b) Address 5357 Lotus

(a) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

(a) Signature of funeral director Sullivan's

(b) Address 2849 No. Euclid Ave.,

(a) NOV 25 1945 (b) J F Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24
year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 16, 1945, to Nov 24, 1945
that I last saw her alive on Nov 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Hypertension (220-120)

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 W H White (M. D. or other) M D

Address 2803 N. Kingshighway Date signed 11-28-45

(Licensed Embalmer's Statement on Reverse Side)

UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Robert L. Brun[illegible]

Licensed Embalmer No. 355[illegible]

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.