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M-2-43  
7-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35464

FILED NOV 23 1945  
318

State File No. \_\_\_\_\_  
Registrar's No. 0280

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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: Bethesda 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 Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5811A Thekla Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ida Mae Juch  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 12  
year 1945 hour 4 minute 30 A. M.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
(b) Name of husband or wife Walter M. Juch  
(c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 13 1878  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November, 1944 to November 12<sup>th</sup>, 1945  
that I last saw her alive on November 12, 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death Bronchopneumonia  
Cerebral Thrombosis  
Duration 8 days

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>10</u>	<u>29</u>	_____ hr. _____ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Cardio-Vascular Royal Disease  
(Include pregnancy within 3 months of death)

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

PHYSICIAN  
Major findings:  
Of operations none  
Of autopsy none  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Unknown Gadberry  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown Breech  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothy Baumgartner  
(b) Address 5811 Thekla Ave.  
17. (a) Burial (b) Date thereof 11-15-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Bethlehem  
18. (a) Signature of funeral director Drehmann-Harral  
(b) Address 1905 Union Blvd.  
19. (a) NOV 14 1945 (b) J. F. Bredack  
(Date received local registrar) (Registrar's signature)

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?  
White at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address 3511 Rusak Date signed 11-13-46

WRITE PLAINLY—USE 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 *Warren A. Carver*  
Licensed Embalmer No. *3534*  
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.