

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35700

State File No.

FILED DEC 7 1945

1003

Registration District No. 318 Primary Registration District No.

Registrar's No. 10199

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Pronounced dead at Barnes Hosp.
(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 Mamie O'Neal

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fred 6. (c) Age of husband or wife if alive 83 years 1889

7. Birth date of deceased Feb. 4 1889
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 19
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Wm. J. Zieger

12. Name Wm. J. Zieger

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

14. Maiden name Henrietta Wallrapp

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

16. (a) Informant Fred O'Neal

(b) Address 4417 Forest Park Boul.

17. (a) Burial (b) Date thereof Nov. 26, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wacker Feldner

(b) Address 3634 Gravois Ave.

19. (a) NOV 26 1945 J. T. Braddock
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 4417 Forest Park Boul.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov. day 23
year 1945 hour 3 minute 00 A.M.

21. I hereby certify that I attended the deceased from
that I last saw h. alive on
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Coronary Heart Disease

Due to
Due to
Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations
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)
(c) Means of injury

23. Signature Alfred Perry M.D. or other
Address Date signed 11/26/45

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

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

00
17
9

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.....

Frank J. Adams

Licensed Embalmer No. *2645*

P. O. Address *St. Louis, Mo*

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.