. S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 15 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38604

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 2777

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town (St Louis) Rich Hgts
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County ....
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 6484 Floyd Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME ANNIE E. ROUSE
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 SINGLE
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept. (Month) 16 (Day) 1877 (Year)
8. AGE: Years 68 Months 2 Days 18 If less than one day ..... hr. ..... min.
9. Birthplace St Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housework
11. Industry or business —
FATHER 12. Name Walter Jones
FATHER 13. Birthplace Ireland (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Anne Finch
MOTHER 15. Birthplace Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Mary L. Cushing
(b) Address 6484 Floyd Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem
18. (a) Signature of funeral director M J Chapin
(b) Address 7446 Manchester
19. (a) 12-10-45 (Date received local registrar) (b) E S McGarvey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4th year 1945 hour 9 minute 35 P.M.
21. I hereby certify that I attended the deceased from August 19, 1945 to Dec 4th, 1945 that I last saw h. alive on Dec 4th, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Terminal Hypostatic Pneumonia	2 days
Due to: Metastatic Carcinomatosis	Chr
Due to: Primary Sigmoid Colon	Chr
Other conditions (Include pregnancy within 3 months of death): 46	

Major findings:
Of operations .....
Of autopsy Yes abscess

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 .....
21. Signature Jarod Yes (M. D. or other) Yes
Address 25 Le Clifton Ave Date signed 12-7-45
Maplewood

(Licensed Embalmer's Statement on Reverse Side)

Dr. [illegible]

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. R. W. Wilkinson

Licensed Embalmer No. 3575

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.