

S. No. 2
M-542
v. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

42437

FILED DEC 28 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2821

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Frances Colored Orphan Home 5
(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 St. Louis 9/1

(c) City or town Normandy
(If outside city or town limits, write "RURAL")

(d) Street No. 3501 St. Marys Lane
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAMES Sister Mary Dolorosa Johnson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 3

5. Color or race Black

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 Don't Know
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>About 43</u>			hr. min.

9. Birthplace Maryland /
(City, town, or county) (State or foreign country)

10. Usual occupation Sister or Nun

11. Industry or business.....

12. Name ? Johnson

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

14. Maiden name Don't Know

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

16. (a) Informant Mother Praxedes

(b) Address Normandy, Mo.

17. (a) Burial (b) Date thereof Dec. 15/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director. Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) 12-17-45 (b) E. M. Gavan M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13
year 1945 hour 12.40 minute P.M. M.

21. I hereby certify that I attended the deceased from 12-6-1945 to 12-13-1945
that I last saw h. alive on 12-13-1945
and that death occurred on the date and hour stated above.

Immediate cause of death. Acute Cardiac dilatation Duration 12 hrs

Due to Bronchopneumonia 7 days

Due to Chronic Myocarditis ?

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy.....

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?
While at work?..... (Specify type of place)

23. Signature Nicholas Vitale (M.D. or other) M.D.

Address 3861 St. Louis Ave. Date signed 12/14/45

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

MOTHER FATHER

Dr. Nicholas S. Vitale,
3861 St. Louis Ave.,
1.3 P.M.
FR. 4113.

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.....

Alfred J. Brediker

Licensed Embalmer No. 2663

P. O. Address. 1125 Hodiamont Ave.,

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.