

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED JAN 21 1946 STANDARD CERTIFICATE OF DEATH

State File No. **706**
Registrar's No. **325**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis Mo**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Josephine Heitkamp Hosp 0**
(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 **50**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **House Spring Mo**
(If rural, give location) **NR**
(e) Citizen of foreign country? _____ (Yes/ or No)
If yes, name country _____

3. (a) PRINT FULL NAME: Mary Jane Mraz
3. (b) If veteran, name war **No** 3. (c) Social Security No. **N**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **10**
year **1946** hour **9 AM** minute _____ M.
21. I hereby certify that I attended the deceased from 11-9-46
_____ 19____ to **11-10-46** 19____
that I last saw h. **er** alive on **11-9-46** 19____
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 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 **Jan 9 1946**
(Month) (Day) (Year)

Immediate cause of death **S. Cerebral Hem. Ism. subventricular rupt**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **157**
Major findings: Of operations _____
Of autopsy **subventricular rupt**

8. AGE: Years Months Days If less than one day
0 0 1 hr. _____ min.

9. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **Child**
11. Industry or business _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **non**
(b) Date of occurrence **non**
(c) Where did injury occur? **non** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
non (Specify type of place)
While at work? **non** (e) Means of injury _____

MOTHER FATHER
12. Name **Harvey Mraz**
13. Birthplace **House Springs Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Barbara Mayer**
15. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)
16. (a) Informant **Harvey Mraz**
(b) Address **House Spring Mo**
17. (a) **Burial** (b) Date thereof **1 11 46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **High Ridge Mo Paul**
18. (a) Signature of funeral director **Kriegshauser**
(b) Address **4228 So. Kings Highway**
19. (a) **JAN 11 1946** (b) **J. Brudeck**
(Date received local registrar) (Registrar's signature)

23. Signature: E. J. [unclear] (M. D. or other)
Address **3252 Lafayette St. St. Louis Mo** Date signed **11-46**

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

Dr Scott
3200 Layft

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.....

No Embalming, Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.