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v. 5-17-39  
X35607

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAR 4 1946

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 489

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 1/2 hours  
57 years  
(Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Lemay 0  
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. # 9, Box 555 0  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOSEPHINE CLAUSEN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 23rd  
year 1946 hour Twelve minute 45 AM.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Henry Clausen

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 20 1887  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 22nd, 1946, to February 23, 1946.  
that I last saw her alive on February 23, 1946,  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>5</u>	<u>3</u>	hr. _____ min.

Immediate cause of death Coronary sclerotic heart disease Duration 5 yrs?

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

10. Usual occupation None

Due to \_\_\_\_\_

Due to \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Hoppie

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bachler

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

16. (a) Informant Henry Clausen - Son

(b) Address R.R. #9, Box 555, Lemay

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

17. (a) Burial (b) Date thereof 2/26/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Church

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? \_\_\_\_\_

18. (a) Signature of funeral director Joseph Hoppie Co.

(b) Address 7420 Michigan

19. (a) 2-27-46 (b) E. D. McFarland  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 0

23. Signature W. W. Carter (M. D. or other) MD

Address 601 Brentwood Blvd. Date signed 2-27-46

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

6  
2  
3

5880

**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

*Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *7027 Gravois*

**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.**