

FILED MAR 30 1946 **STANDARD CERTIFICATE OF DEATH**
318 1003

State File No. _____
Registrar's No. **2499**

Registration District No. **318** Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
City Hospital # 1
(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 **Amanda Hosna**

3. (b) If veteran, name war **No**

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Div**

6. (b) Name of husband or wife **Joseph** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **About 1897**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
Abt 49	0	0	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown**

13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Michael A. Peckron**
(b) Address **2211 1/2 Menard Street**

17. (a) **Burial** (b) Date thereof **3/16/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews**

18. (a) Signature of funeral director **Wm. G. Myer**
(b) Address **11926 Allen Av**

19. (a) **MAR 15 1946** **J. F. Bradeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

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

(d) Street No **1819a S 12th Street**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14**
year **1946** hour **7.40** minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Kidney, renal lithiasis, bilateral with obstruction;
Kidney, pyelonephritis, bilateral uremia.

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)

(e) Means of injury _____

23. Signature **Dr. J. F. Bradeck** (M. D. or other) **3**
Address _____ Date signed **3/15/46**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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..... *Benj. C. Duncan*

Licensed Embalmer No. *2272*

P. O. Address. *1926 Allen*

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.