

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. **ED APR 12 1946**

Primary Registration District No. **1003**

Registrar's No. **3082**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Firmin Desloge Hospital  
(If not in hospital or institution, write street number or location)

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

In this community 18 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 2632 Accomac Street  
(If rural, give location)

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

3. (a) PRINT FULL NAME Ethel Meder

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Werner 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased: September 14, 1896  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st, year 1946 hour 8: minute 25 A. M.

21. I hereby certify that I attended the deceased from 3/28/46 19... to 3/31/46 19...; that I last saw h. er alive on 3/31/46 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Duration 4 days

8. AGE: Years 49 Months 6 Days 17 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Arteriosclerosis - Generalized Uncertain

9. Birthplace Anapolis, Missouri  
(City, town, or county) (State or foreign country)

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

Other conditions Hypertensive Cardio-vascular disease Uncertain  
(Include pregnancy within 3 months of death)

10. Usual occupation house-wife

11. Industry or business at home

12. Name Frank Parker

13. Birthplace Washington County, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Robinson

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

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

Of autopsy No autopsy

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Florence Damon

(b) Address 2632 Accomac Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-46  
(Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director H. W. McLaughlin

(b) Address 2301 Lafayette Av. St. Louis, Mo.

19. (a) APR 2 1946 (Date received local registrar) J. Z. Bruneau (Registrar's signature)

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

(e) Means of injury no

23. Signature G. O. Brown (M. D. or other) MD

Address 1325 S. Grand Blvd. Date signed 4/1/46

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

10343

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**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.....

*K R Cooper*

Licensed Embalmer No.....

*3633*

P. O. Address.....

*2301 Lafayette 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.**