

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

750919  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18841  
State File No. \_\_\_\_\_  
Registrar's No. **4801**

**FILED JUN 13 1946**  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri.  
(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:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
Life (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5337a Nagel  
Memorial (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Margaret Roney  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 27th  
year 1946 hour 1:48 minute P M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Cornelius  
7. Birth date of deceased: May 26 1902  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 22 1946 to May 27th, 1946  
that I last saw her alive on May 27th, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 44 Months 0 Days I  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death general paresis Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to 30

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

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

10. Usual occupation Retired Saleswoman  
11. Industry or business \_\_\_\_\_  
12. Name James Dempsey  
13. Birthplace New York  
(City, town, or county) (State or foreign country)  
14. Maiden name Cigra Weston  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy general paresis  
Underline the cause to which death should be charged statistically.

16. (a) Informant Eunice Firoz  
(b) Address 5337a Nagel  
17. (a) Burial (b) Date thereof 6/29/46  
(Burial, cremation, or removal) (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 New St. Marcus Cem.  
18. (a) Signature of funeral director J. L. Ziegenhein & Sons  
(b) Address 7027 Gravois Ave.  
19. (a) MAY 29 1946 (Date received local registrar)  
F. Brudeck (Registrar's signature)

23. Signature [Signature] (b) Date of injury 5/27/46  
Address 515 Lafayette Date signed \_\_\_\_\_

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

MOTHER FATHER

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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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address Overland 14 Mo

**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.**