

S. No. 2
OM-5-43
Rev. 5-17-39
I X36971

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28375 ✓

State File No. 0

FILED AUG 12 1946

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1647

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
320 St. Marie /
(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 Missouri (b) County St. Louis

(c) City or town Rural - Florrisant
(If outside city or town limits, write "RURAL")

(d) Street No. 320 St. Marie
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mae M. Sommers

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Walter

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

7. Birth date of deceased Dec 16 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>7</u>	<u>20</u>	_____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

12. Name Hy. A. Hertgrass

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

14. Maiden name Alvina Oberschelp

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

16. (a) Informant Mabel Heitgrass

(b) Address 320 St. Marie

17. (a) Burial (b) Date thereof 8/9/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director PROVOST MORTUARY

(b) Address 3710 N. Grand Blvd.

19. (a) 8-8-46 (b) E. M. Garaway
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6
year 1946 hour 6 minute 00 A.M.

21. I hereby certify that I attended the deceased from May 21 — 1946 to Aug 6 — 1946
that I last saw her alive on Aug 6 — 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Duration 5 days

Due to Chronic myocarditis 5 years

Due to My nephritis 13 1/2 3 years

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

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

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 Ray Johnson (M. D. or other) _____
Address Johnson, Mo. Date signed 8/11/46

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

21614

360

V.
M.
P.

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..... *V E Morris*

Licensed Embalmer No. *3360*

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.

10/11