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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31968

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 8035

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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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. 4434 Forest Park
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

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3. (a) PRINT FULL NAME CHARLOTTE LINTON

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Paul Linton

6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased February (Month) 22 (Day) 1926 (Year)

8. AGE: Years 20 Months 6 Days 25 If less than one day hr. min.

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

10. Usual occupation Salesgirl

11. Industry or business

FATHER
12. Name Unknown Metheny
13. Birthplace East Prairie (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace East Prairie (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Paul Linton
(b) Address 4434 Forest Park

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-17-46 (Month) (Day) (Year)
(c) Place: burial or cremation East Prairie, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 17 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17th year 1946 hour 5:45 minute A M.

21. I hereby certify that I attended the deceased from 9/13/46, 19..., to Sept. 17th, 1946; that I last saw her alive on Sept. 17th, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Generalized peritonitis	6 days
Due to Perforated appendix	6 days
Due to	
Other conditions (Include pregnancy within 3 months of death) Lobar pneumonia, bilateral	48 hrs

Major findings:
Of operations Perforated appendix & generalized peritonitis
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Frances R. Burns (M. D. or other)
Address 1515 Lafayette, St. Louis Date signed 9-17-46

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.