DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32246

State File No.

FILED SEP 318 1946

Registration District No. 1003 Primary Registration District No.

Registrar's No. 8011

1. PLACE OF DEATH:
(a) County St. Louis Mo.
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2234 Montana St. (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 11 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 000
(c) City or town St. Louis Mo. (If outside city or town limits, write "RURAL") 1517
(d) Street No. 2234 Montana (If rural, give location) 9
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Julia A. Staat
3. (b) If veteran name war —
3. (c) Social Security No. —

4. Sex F.
5. Color or race W.
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Deceased (George)
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Mar. (Month) 29. (Day) 1870 (Year)

8. AGE: Years 76 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Jefferson Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name John McCreery
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
14. Maiden name Maryland Mass.
15. Birthplace Jefferson Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Edward Staat
(b) Address Kimmswick Mo.
17. (c) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18-1946 (Month) (Day) (Year)
(c) Place: burial or cremation St Josephs Cem. Kimmswick Mo.
18. (a) Signature of funeral director Hellgtag Funeral Home
(b) Address Kimmswick Mo.
19. (a) SEP 17 1946 (Date received local registrar) (b) J. J. Bredrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14 year 1946 hour 8 minute 50 A. M.
21. I hereby certify that I attended the deceased from August 30, 1946, to Sept 13, 1946, that I last saw her alive on Sept 13, 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary artery disease with Chronic Myocarditis	2 yrs
Due to (and bronchial asthma)	5 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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) 0
While at work? (e) Means of injury

23. Signature George J. O'Sullivan (M. D. or other) MD
Address 621 N. Schermer Date signed 9-14-46

(Licensed Embalmer's Statement on Reverse Side)

1108

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. Elmer Heiligtag

Licensed Embalmer No. 3571.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
-41
27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318 Primary Registration District No. Registrar's No. 8011

1. PLACE OF DEATH:
(a) County
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Julia A Staat
3. (b) If veteran name war
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 3 (Month) - 29 (Day) - 18 (Year)

8. AGE: Years 76 Months 5 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-17-46 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 10
year 1946 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

OCT 14 1946

32246