

S. No. 2
M-5-43
5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35445

State File No. _____

FILED NOV 7 1946
318

Primary Registration District No. 1003

Registrar's No. 9033

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:
Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson ⁵⁰

(c) City or town Hillsboro
(If outside city or town limits, write "RURAL") ^{NR. 3}

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nevada Muse

3. (b) If veteran, name war *****

3. (c) Social Security No. *****

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20th day October
year 1946 hour 7:00 minute A. M.

4. Sex Female 5. Color or race White

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

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

7. Birth date of deceased January 10 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-5-1946 to 10-20-1946 that I last saw her alive on 10-20-1946 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

80 9 10 hr. _____ min.

Immediate cause of death Pulmonary embolus Duration 15 minutes

Due to Post Operative 7 days

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

10. Usual occupation At Home

Due to Ecto-ileostomy Carcinoma of caecum 6 mos

11. Industry or business _____

12. Name Philip M. Ogan

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Anna Smith

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

Other conditions (Include pregnancy within 3 months of death) Senility - cachexia

Major findings: PHYSICIAN
Of operations _____

Of autopsy H6

Underline the cause to which death should be charged statistically.

16. (a) Informant Nevada Muse

(b) Address 5740 Holly Hills Ave

17. (a) Cremation (b) Date thereof Oct 23 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Gregory Bro

(b) Address 6409 Gravois

19. (a) OCT 22 1946 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____

23. Signature Walter H. Johnson (M. D. or other) _____
Address 2602 S Grand Date signed 10/22/46

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

MOTHER FATHER

1263 / 688
Pro-5172
Dr. W. S. V. Tucker
2602 S. Grand

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 Homer W. Fritz

Licensed Embalmer No. 3882

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.