

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED *21 1946*
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35687**
Registrar's No. **8653**

Registration District No. _____ Primary Registration District No. _____

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: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
In this community 65 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County anc
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9/11
(d) Street No. 2103 Desoto Avenue
(If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME MARY WAGNER
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 7th
year 1946 hour 11 minute 40 A.M.

4. Sex Female **5. Color or race** White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Joseph G. Wagner
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 16, 1860
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
May 4, 1946 to Oct. 7, 1946
that I last saw her alive on Oct. 7, 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>9</u>	<u>21</u>	_____ hr. _____ min.

Immediate cause of death
Chr. Myocarditis 5 yrs.
Systemic atherosclerotic Cardiovascular Disease
Due to _____

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

Other conditions Fracture, intertrochanteric rt. hip. 7/3/46
(Include pregnancy within 3 months of death)

10. Usual occupation At home

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name John Bulan

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Josephine Roth

(b) Address 2103 Desoto Avenue

17. (a) Burial (b) Date thereof 10-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calyvary Cemetery

18. (a) Signature of funeral director _____
(b) Address 2117 East Grand Blvd.

19. (a) OCT 8 1946 (b) J. F. Brebeck
(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) Accident
(b) Date of occurrence July 3, 1946
(c) Where did injury occur? Residence
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
See above
(Specify type of place)
While at work _____ (b) Means of injury Fall

23. Signature Charles M. [unclear] (M. D. or other) 10/8/46
Address 3711 Lee **Date signed** _____

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

MOTHER FATHER

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..... *Frank A. Moore*

Licensed Embalmer No. *3041*

P. O. Address *2117 E. Grand*

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.