

S. No. 2
M-5-43
7. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38142

State File No. _____

FILED NOV 25 1946
Registration District No. _____

Primary Registration District No. 3068

Registrar's No. 3313

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
36957

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution: H MAPLEWOOD NURSING HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 MO. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS 76

(c) City or town MAPLEWOOD 5
(If outside city or town limits, write "RURAL")

(d) Street No. 7103 PLATEAU 3
(If rural, give location)

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

3. (a) PRINT FULL NAME JOSEPHINE VOLK

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

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

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

7. Birth date of deceased FEBRUARY 25 1868
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 16TH
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 15th 1946, to Nov. 15th 1946
that I last saw her alive on Nov 15th 1946
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>8</u>	<u>15</u>	hr. _____ min. _____

Immediate cause of death Cerebral Hemorrhage Duration 36 hrs

Due to Ch. Cardio-vascular disease Ch.

Due to diffuse arterio-sclerosis Ch.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) 131a

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name BINDER 4

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

14. Maiden name NOT KNOWN

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

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? _____

16. (a) Informant CHRISTINA HUKER

(b) Address 7103 PLATEAU

17. (a) BURIAL (b) Date thereof 11-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

While at work? _____ (Specify type of place)

(f) Means of injury _____

23. Signature H. J. Cloghan (M. D. or other) _____
Address 2816 S. 10th Ave Date signed 11/17/46

18. (a) Signature of funeral director M. J. CLOGHAN

(b) Address 7146 MANCHESTER

19. (a) 11-19-46 (b) C. J. Cloghan
(Date received local registrar) (Registrar's signature)

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.....

W. Wilkinson

Licensed Embalmer No.....

3575

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.