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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 7 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

42514
State File No. 11048
Registrar's No. 1002

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:
St. Anthony's Hospital
(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 Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5210 Louisiana Ave.
(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 Infant Homa
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 single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased December 23, 1946
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 23
year 1946 hour 1 minute 45 P.M.
21. I hereby certify that I attended the deceased from
12.23.46, 19... to 12.23.46, 19...
that I last saw her alive on 12.23.46, 19...
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
hr. 30 minutes
9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation nil

Immediate cause of death
Respiratory Arrest Duration 1 hr.
Due to.....
Due to.....
Other conditions Cardiac dilatation 1 hr
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business.....
12. Name Louis Homa
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Eleanor Pohl
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

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

16. (a) Informant Louis Homa
(b) Address 5210 Louisiana Ave.
17. (a) (Burial, cremation, or removal) (b) Date thereof 12/24/46
(Month) (Day) (Year)
(c) Place: burial or cremation Old St. Peter & Paul
18. (a) Signature of funeral director Arthur Fambel
(b) Address 6322.50 Grand Blvd
19. (a) DEC 24 1946 J. J. Brednich
(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) (e) Means of injury.....
23. Signature J. J. Brednich (M. D. or other) M. D.
Address 6322.50 Grand Blvd Date signed 12/23/46

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

J. W. Bentley

Licensed Embalmer No.....

3653

P. O. Address.....

St Louis, Mo

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

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

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ST. LOUIS
(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

3. (a) PRINT FULL NAME

Homa

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 _____

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

7. Birth date of deceased Dec 23 1910
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 30 min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 1946 (b) J. F. Brueckel
(Date received local registrar) (Registrar's Signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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 _____

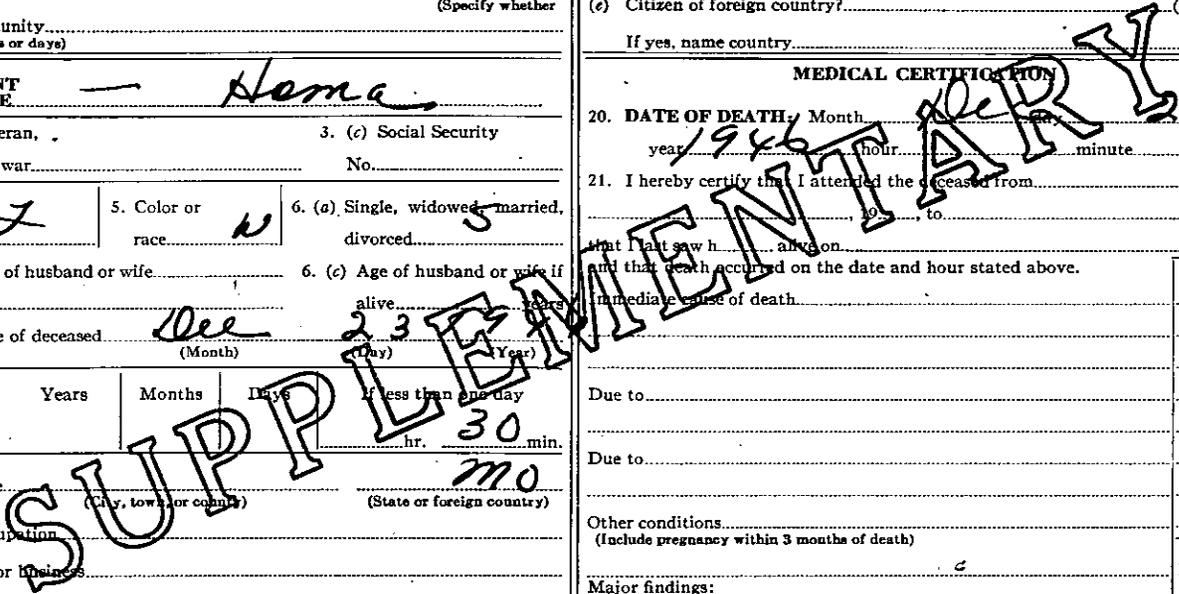
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____



42514