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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2364

FILED FEB 33 1947

Registration District No. 33 1947

Primary Registration District No. 1003

Registrar's No. 828

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. Johns Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 - weeks (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 0 00 517

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 5448 Cabanne Ave (If rural, give location) 9 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sister Mary Benigna Cotter

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 S. 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. 17th. 1861 (Month) (Day) (Year)

8. AGE: Years 85 Months 4 Days 7 If less than one day hr. min.

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

10. Usual occupation Religious

11. Industry or business

FATHER
12. Name Maurice Cotter
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Bridget Ford
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Sister M. Raphael

(b) Address 5448 Cabanne Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-47 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) JAN 24 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 24th year 1947 hour 8 minute 05 M.

21. I hereby certify that I attended the deceased from January 17th, 1947, to January 24, 1947 that I last saw her alive on January 24th, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Bronchopneumonia	6 days
Due to Hypertension Cardio-Vascular	One
Due to disease	Year +
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 0

23. Signature A. P. Wunsch (M. D. or other)

Address 306 Humboldt Bldg Date signed January 24/47

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.