

No. 2
5-1-3
1-1-3
2-36671

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

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2151**

1. PLACE OF DEATH:
 (a) County St. Louis Mo.
 (b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Infirmiry Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8/1/46 to 3/1/47
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County St. Louis
 (c) City or town ST. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 6017 Marquette
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Dora Holdenried
 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 Married
 6. (b) Name of husband or wife Henry Holdenried
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec. 5, 1877
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 1
 year 1947 hour 12 minute 55 P.M.
 21. I hereby certify that I attended the deceased from 8 / 1 / 1946 to 3 / 1 / 1947
 that I last saw her alive on 3 / 1 / 1947
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>2</u>	<u>26</u>	hr. _____ min. _____

Immediate cause of death
(1) Diabetic melitis 1946
(2) Myocardial insufficiency time unknown
 Due to (3) Chronic glomerular-nephritis 1946
 Due to (4) Hydertrophic arthirtis -1946
 Other conditions 61
(Include pregnancy within 3 months of death)

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name Fred Jost
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

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

MOTHER {
FATHER {
 16. (a) Informant City Infirmiry
 (b) Address 5800 Arsenal St.
 17. (a) Burial (b) Date thereof 3/4/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Memorial Park Cemetery
 18. (a) Signature of funeral director Edith E. Ambruster
 (b) Address 4234 Manchester
 19. (a) MAR 3 1947 (b) [Signature]
(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) _____ Means of injury 0
 23. Signature Palmer Priscine Bowditch (M. D. or other) _____
 Address City Infirmiry Date signed 3-3-47

10000

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 *Flora Eymck*
Licensed Embalmer No. 1284
P. O. Address St Louis Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 2151

Registration District No. 318

Primary Registration District No. 1003

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 Dora Haldenried

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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased: Dec (Month) 5 (Day) (Year)

8. AGE: Years 69 Months 2 Days 10 (If less than one day, hr. _____ min. _____)

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

10. Usual occupation Self-employed

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) J. F. Bredeek (Registrar's signature) MAR 19 1917

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 March year 1917 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 _____

SUPPLEMENTARY

USE CHANGING BLOCK FOR PERMANENT RECORD

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