

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **7364**

FILED MAR 31 1947

Registration District No. **1947**Primary Registration District No. **6076**Registrar's No. **566**

## 1. PLACE OF DEATH

(a) County Pine Lawn  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Shamrock Rest Home 4  
 (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 Sophia Cregan

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 Manuary 12 1970  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 1 17 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph Placht  
 13. Birthplace Austria  
 (City, town, or county) (State or foreign country)

14. Maiden name Don't know  
 15. Birthplace Don't know  
 (City, town, or county) (State or foreign country)

16. (a) Informant M. E. Lehmann  
 (b) Address 7508 Weil  
 17. (a) Burial (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Weick Bro. Und. Co.  
 (b) Address 2201 S. Grand Bl  
 19. (a) 3-13-47 (b) Ruth J. Allen MD  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96  
 (c) City or town St. Louis Gaudemelle  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3709 Menola  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th  
 year 1947 hour 5 minute 50 A. M.

21. I hereby certify that I attended the deceased from April 29, 1946, to March 9, 1947,  
 that I last saw her alive on March 9, 1947,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Arricular fibrillation 93d Duration 6 mos  
 Due to arteriosclerotic heart disease - (myocarditis) 5 yrs  
 Due to \_\_\_\_\_

Other conditions Senile dementia 1 yr.  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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 Lewis Littmann MD (M. D. or other) MD  
 Address 823 Clayton Rd Date signed 3/10/47

*Dr. Lewis Hutton*  
*APR 10 1947*  
*8231 Claytown Rd*

V.S. No. 2  
36M-1245  
APR 11 1947

**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 *Harry A. Stewart*  
Licensed Embalmer No. *3722j*  
P. O. Address *2201 S. 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.