S. No. 2
M—5-43
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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. 7465

FILED MAR 14 1947

Registration District No. 5/7 — Primary Registration District No. 4466 — Registrar's No. 546

1. PLACE OF DEATH:

(a) County: ST LOUIS
(b) City or town: SHREWSBURY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7421 SUTHERLAND
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: ST LOUIS 96
(c) City or town: SHREWSBURY (If outside city or town limits, write "RURAL") 15
(d) Street No. 7421 SUTHERLAND (If rural, give location) 0
(e) Citizen of foreign country? ____ (Yes or No) 0
If yes, name country ____

3. (a) PRINT FULL NAME: PETER A ROCK
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife: ELISABETH MUNDELL
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: OCT (Month) 10 (Day) 1863 (Year)
8. AGE: Years 83 Months 4 Days 27 If less than one day ____ hr. ____ min.
9. Birthplace: RICHLANDING (City, town, or county) PENN (State or foreign country) 1
10. Usual occupation: RETIRED
11. Industry or business: INSURANCE BROKER
FATHER 12. Name: PETER ROCK
13. Birthplace: IRELAND (City, town, or county) (State or foreign country) 4
MOTHER 14. Maiden name: UNKNOWN
15. Birthplace: " (City, town, or county) (State or foreign country) 9
16. (a) Informant: Mrs Grace Cook
(b) Address: 7421 Sutherland
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: MARCH 12, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: NEW SS. PETER + PAUL
18. (a) Signature of funeral director: Cullen + Kelly
(b) Address: 4386 LINDELL BLVD
19. (a) 3-11-47 (Date received local registrar) (b) Ruth Jillen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9 year 1947 hour 10:30 minute P. M.
21. I hereby certify that I attended the deceased from April 2, 1944, to 3/9, 1947; that I last saw him alive on 3/8, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Decompensation	6 days
Due to: Generalized Arterio sclerosis	years
Due to: 95 2	
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) 0
While at work? (e) Means of injury
23. Signature: [illegible] MD (M. D. or other)
Address: 671 E Big Bend Rd Date signed: 3/10/47
Webster Groves, Mo

(Licensed Embalmer's Statement on Reverse Side)

APR 2 - 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 Albert Mayfield

Licensed Embalmer No. 13077

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.