

S. No. 2
-12-45
5-17-39
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11543

State File No.

FILED APR 14 1949
318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

3436

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:
ST. JOHNS HOSP. 0
(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 ST. LOUIS 96
(c) City or town ROCK HILL VILLAGE 214
(If outside city or town limits, write "RURAL")
(d) Street No. 2922 WINGATE COURT
(If rural, give location) NR 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CONSTANCE M. SILVERMAN

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 STANLEY SILVERMAN
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased OCTOBER 14, 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
31 5 17 hr. min.

9. Birthplace LAINE LANDER WIS.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name PETERSON

13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name CONSTANT

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant MR. STANLEY SILVERMAN

(b) Address 2922 WINGATE COURT

17. (a) REMOVAL (b) Date thereof 4-1-49
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAINE LANDER, WIS.

18. (a) Signature of funeral director M. CLOGHAN

(b) Address 7146 MANCHESTER

19. (a) MAR 31 1949 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 30
year 1949 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from for
one day 3-30, 1949 to _____, 19____;
that I last saw h. alive on 3-30, 1949
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration hrs.

Due to malignant Hypertension 3 yrs.

Due to _____

Other conditions [Signature]
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Ruptured cerebral artery

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 Michael Dulick (M. D. or other) 0

Address Brentwood, Mo Date signed 3-31-49

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

JUL 1 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..... *Ernest W. Spiller*

Licensed Embalmer No..... *4080*

P. O. Address.....

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.