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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11959**
Registrar's No. **634**

FILED MAR 31 1947

Registration District No. _____ Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County **ST. Louis**

(b) City or town **Koch Mo**

(c) Name of hospital or institution: **Robert Wood Memorial Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **9 11 days**
(Specify whether)

In this community _____
years, months or days **MAYLE**

3. (a) PRINT FULL NAME **Maude Jerome Joseph**

3. (b) If veteran, name war _____

3. (c) Social Security No. **you**

4. Sex **W**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife **Mary Maule**

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

7. Birth date of deceased **April 19 1883**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	10	27	hr. _____ min.

9. Birthplace **Greene Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business _____

MOTHER FATHER {

12. Name **John Maule Mo**

13. Birthplace **Greene Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Jessie Mauriger**

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

16. (a) Informant **Robert Wood Memorial Hospital**

(b) Address **Koch, Mo**

17. (a) **BURIAL** (Burial, cremation, or removal)

(b) Date thereof **3-19-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **WENTZVILLE, MO**

18. (a) Signature of funeral director **T. E. PITMAN**

(b) Address **WENTZVILLE, MO**

19. (a) **3-19-47** (Date received local registrar)

(b) **Robert Wood Memorial Hospital** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO**

(b) County **92**

(c) City or town **Wentzville**
(If outside city or town limits, write "RURAL") **3**

(d) Street No. _____
(If rural, give location) **1**

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **16**

year **1947** hour **2** minute **45 A** M.

21. I hereby certify that I attended the deceased from **10-17-1944** to **3-16-1947**

and that I last saw him alive on **3-15-1947**

and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Pulmonary Tuberculosis**

Duration **3 years**

Due to **136**

Due to _____

Other conditions: (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)

(c) Means of injury _____

23. Signature **John T. DeGisi** (M. D. or other)

Address **Robert Wood Memorial Hospital**

Date signed **3/16-47**

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 Elmo R. Caldwell

Licensed Embalmer No. 4077

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..