

No. 2  
-12-45  
5-17-39  
P 1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15190**  
Registrar's No. **4046**

FILED MAY 1 1947  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(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:  
St. Louis City Hospital Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Three Days  
(Specify whether \_\_\_\_\_)  
In this community Twenty Year  
years, months or days

3. (a) PRINT FULL NAME ALICE HOBUSCH  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 488-07-1545

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Alfred  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 21 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 5 27 hr. min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Geo. W. Harrison

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

14. Maiden name Leona Conally

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

16. (a) Informant Mark H. Smallwood

(b) Address 2614 St. Vincent

17. (a) Burial (b) Date thereof 4 20 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Solon, Iowa

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) APP 10 (b) W. H. F. G. G. G.  
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Gas  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2614 St. Vincent  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 18,  
year 1947 hour 3:20 minute 8 M.  
21. I hereby certify that I attended the deceased from 4-14-47  
19\_\_\_\_, to 4-18-47, 19\_\_\_\_;  
that I last saw her alive on 4-18-47, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intra-cranial hemorrhage Duration 48 hrs  
Due to Hypertensive cardio-vascular disease 5 years  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 W. H. F. G. G. G. (M. D. or other) \_\_\_\_\_  
1515 Lafayette Date signed 4-18-47

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

*J. R. Cooper*

Licensed Embalmer No..... *3633*

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.**