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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 21 1947
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 15898
Registrar's No. 3840

Registration District No. 318 Primary Registration District No. 1003

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:
Josephine Heitkamp Hospt. 1)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 5 mos.
(Specify whether
In this community..... Life
years, months or days)

3. (a) PRINT FULL NAME MARY B. WOODMAN
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, 2 Widowed
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... July 2 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 9 8 hr. min.

9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation Hwk.

11. Industry or business.....

12. Name John P. Tichacek 8
13. Birthplace Bohemia (City, town, or county) (State or foreign country)

14. Maiden name Unknown 9
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Dr. Arnold J. Woodman
(b) Address 3907 McDonald

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof. 4/12/47
(Month) (Day) (Year)
(c) Place: burial or cremation. New SS' Peter & Paul

18. (a) Signature of funeral director. Petty Funeral Home
(b) Address 3029 Lafayette

19. (a) APR 11 1947 (Date received local registrar) (b) J. F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3907 McDonald (If rural, give location)
(e) Citizen of foreign country?..... No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 10TH
year 1947 hour 10 minute 35 P.M.
21. I hereby certify that I attended the deceased from.....
11-14-46, 19....., to 4-10, 19.....
that I last saw h. ER alive on..... 4-10, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death UREMIA Duration 3 DAYS

Due to CARCINOMA OF URINARY BLADDER 11 MONTHS

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) 52

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?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature J. In Tracish (M. D. or other)
Address 508 N. GRAND Date signed 4-11-47

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

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.....

David Lee Jensen

Licensed Embalmer No.....

P. O. Address.....

3074 Jaycee

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.