S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18933

FILED MAY 22 1947

70663

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1850

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 (Specify whether
In this community D
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis
(c) City or town ~~St Louis~~ Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 6714 WAGNER AVENUE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME IDA HESS
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 WILLIAM P. HESS
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased APRIL (Month) 21 (Day) 1884 (Year)
8. AGE: Years 63 Months 0 Days 21 If less than one day hr. min.
9. Birthplace ST. LOUIS (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business HOUSEWIFE
MOTHER FATHER
12. Name WILLIAM P. COTTLE
13. Birthplace OHIO (City, town, or county) (State or foreign country)
14. Maiden name RACHEAL LAMBOY
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant William P Hess
(b) Address 6714 WAGNER AV.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/16/47 (Month) (Day) (Year)
(c) Place: burial or cremation LAUREL HILL CEM.
18. (a) Signature of funeral director J. M. Mullen
(b) Address 5165 DELMAR BL.
19. (a) MAY 14 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th year 1947 hour 6:20 minute A M.
21. I hereby certify that I attended the deceased from 4-24-47, 19..., to 5-12-47, 19...; that I last saw h. er alive on 5-12-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral vascular accident	3 wks?
Due to: Hypertensive encephalopathy	2 yrs?
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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)
While at work? (e) Means of injury

23. Signature J. Lowry Brown, M.D. (M. D. or other)
Address 1515 Lafayette Date signed 5-12-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....,

rking under my personal supervision.

Signed.....- F. G. Farris

Licensed Embalmer No. 3384

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.