

No. 2
-12-45
5-17-39

DEPARTMENT OF COMMERCE

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1955

FILED MAY 21 1947

State File No. _____

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 1039

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Res: 6301 Alamo.
(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
(c) City or town Clayton 5,
(If outside city or town limits, write "RURAL")
(d) Street No. 6301 Alamo.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Johanna Happel.

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles Happel, 6. (c) Age of husband or wife if alive Deed years

7. Birth date of deceased 1 12 1870
(Month) (Day) (Year)

8. AGE: Years 77. Months 3. Days 25. If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name Casper Gockel. 4
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Margaret Pick.
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Charles Happel
(b) Address 6301 Alamo.

17. (a) Entombment (Burial, cremation, or removal) (b) Date thereof 5-9-47.
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Maus.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) 5-12-47 (b) Carla J. Hays
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th
year 1947. hour 6:09 minute a. M.

21. I hereby certify that I attended the deceased from 2-4 1947 to 5-7 1947
that I last saw her alive on 5-7 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Lymphosarcoma subcuticular,
Due to apronotomular, lumbar
rigid, 6 mos
Due to 55K
Other conditions ✓
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: as above
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)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 3720 Clayton Date signed 5/7/47

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

JUL 18 1948
AUG 25 1947

Dr. Spornstad
3770 Washington
NE-0870
11 to 1

AUG 21 1948

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 Clarence A. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, Mo.

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.