

No. 2  
-1/47  
-17-39

FILED JUN 30 1947 318

1003

Registration District No. .... Primary Registration District No. ....

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **City Hospital 0**  
(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.....  
(c) City or town..... **St. Louis Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3940 Tholozan Avenue**  
(If rural, give location)  
(e) Citizen of foreign country?..... **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Marian A. Hovey**  
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, **widowed**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **September 20th, 1863**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>83</b>	<b>8</b>	<b>21</b>	.....hr. ....min.

9. Birthplace **Richport Conn.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **nil**  
11. Industry or business.....  
12. Name **Math. Jones**  
13. Birthplace **Richport Conn.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Alice Currie**  
15. Birthplace **Richport Conn.**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Nelson Hovey**  
(b) Address **3940 Tholozan, St. Louis, Mo**  
17. (a) **burial** (b) Date thereof **June 14, 1947**  
(Burial, cremation, or exposure) (Month) (Day) (Year)  
(c) Place: burial or cremation **New St. Marcus Cemetery**  
18. (a) Signature of funeral director **Wacker-Selders N. & Co.**  
(b) Address **3634 Gravois, St. Louis, Mo.**  
19. (a) **JUN 12 1947** (b) **J. F. Bredack**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **11th**  
year **1947** hour **1** minute **20 P.** M.  
21. I hereby certify that I attended the deceased from **16** **June 9** 19**47**  
that I last saw b **en** alive on **June 9** 19**47**  
and that death occurred on the date and hour stated above. Duration

Immediate cause of death **Fracture of neck spine. Rigor**  
Due to **Fall in yard at home**  
**Aortic dissection**  
Due to **Shuntion**  
Other conditions..... (Include pregnancy within 3 months of death)  
Major findings: **Inclined to above**  
Of autopsy.....  
PHYSICIAN  
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, list the following:  
(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence **all part 1 1947**  
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..... (Specify type of work)  
23. Signature **J. F. Bredack** (M. D. or other)  
Address **11504 S. Grand** Date signed **6/12/47**

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

MOTHER FATHER

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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 Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Stamino

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JulyRegistrar's No. 577Registration District No. 318Primary Registration District No. 1003

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

## 3. (a) PRINT FULL NAME

Maria A. Healey

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 20 1906  
(Month) (Day) (Year)8. AGE: Years 83 Months 8 Days \_\_\_\_\_  
(Unless than one day hr. min.)9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)10. Usual occupation Suppl

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

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Breck  
(Date received local registrar) (Registrar signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

22343

22343