S. No. 2
M—1/47
r. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 30 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22472

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5882

WRITE PLAINLY—USING 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: 6225 Bowman Ave.
(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 Mo. (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 6225 Bowman Ave. 9
(If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ELEANOR L. MACE

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 19 (Day) 1920 (Year)

8. AGE:

Years	Months	Days	If less than one day
26	11	25	hr. min.

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

10. Usual occupation Invalid

11. Industry or business

FATHER
12. Name Paul A. Mace
13. Birthplace San Diego Cal.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Irene Call
15. Birthplace East St. Louis Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Paul A. Mace
(b) Address 6225 Bowman Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 17 47 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4228 So. Kingshighway Bl.

JUN 17 1947

19. (a) (Date received local registrar) (b) J. F. Breseck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1947 hour 9:27 minute A. M.

21. I hereby certify that I attended the deceased from 6/19, 1920 to 6/14, 1947
that I last saw her alive on 6/14, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho-Pneumonia malnutrition	7 days
Due to Spastic Paralysis	26 yrs.
Due to Epilepsy	15 yrs.
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 P. M. Grueb (M. D. or other) M.D.

Address 3402 California Date signed 6/16/47

P.M. GRUEB

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.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....3024

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.