

No. 2
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 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25151

FILED AUG 15 1947

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 135

1. PLACE OF DEATH:

(a) County St Charles
 (b) City or town St Charles
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St Joseph
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 wk (Specify whether
 In this community life years, months or days)

3. (a) PRINT FULL NAME Mary Bazan

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

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Stanley Bazan 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Feb 18 1878
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>5</u>	<u>20</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Emil Sonnek

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

14. Maiden name _____

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

16. (a) Informant Dr W G Bazan

(b) Address Robertson Mo

17. (a) Burial (b) Date thereof 8/11/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Overland Mo

19. (a) 8-12-47 (b) Faune Hamilton
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
 (c) City or town St Louis (If outside city or town limits, write "RURAL") 17
 (d) Street No. 5337 Easton (If rural, give location) 9
 (e) Citizen of foreign country? No (Yes or No) 1
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
 year 1947 hour _____ minute 4:17 P.M.

21. I hereby certify that I attended the deceased from 8 March 1947 to 8 Aug 1947
 that I last saw her alive on 8 Aug 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration _____

Due to Coronary Occlusion or old Rheumatic Heart

Due to on

Other conditions Bronchopneumonia 2 days
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy 94A

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? 0

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

Signature J. E. Hengen (M. D. or other) MD

Address Pat on file Date signed 9 Aug 47

RECEIVED
District Health Officer No. 9,
District No. 8-14-47
Date

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 *Al C Ostmann*
Licensed Embalmer No. *3478*

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.

State File No. aug
Registrar's No. 1015

Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(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
In this community years, months or days)

3. (a) PRINT FULL NAME

Mary Logan

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced sc

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

7. Birth date of deceased Jul 18
(Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days mo (if less than one day) hr. min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Aug 12-47 (b) Frankie Hamilton
(Date received local registrar) (Registrar's 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 Aug Year 1947 Hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from 1947 to 1947 that I last saw him sc alive on 1947 and that death occurred on the date and hour stated above. Immediate cause of death.

Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

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 Frankie Hamilton (M. D. or other)
Address Date signed

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

SUPPLEMENTARY

MISSOURI
DEATH

5-25/51