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. 25767

FILED JUL 21 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6528

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: Deaconess Hospital
(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)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 727 N. Union Blvd.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Ruth Page Landes

3. (b) If veteran, name war No

3. (c) Social Security No. 559-18-0540

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 20 (Day) 1900 (Year)

8. AGE: Years	Months	Days	If less than one day
47	2	20	hr. min.

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

10. Usual occupation Clerk

11. Industry or business U.S. Government

MOTHER FATHER

12. Name Dewitt Landes

13. Birthplace Augusta Co. (City, town, or county) Virginia (State or foreign country)

14. Maiden name Ora Page

15. Birthplace Albremarle Co., (City, town, or county) Virginia (State or foreign country)

16. (a) Informant Ora Landes

(b) Address 1410 Park Pl., Charlottesville, Va.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-10-47 (Month) (Day) (Year)

(c) Place: burial or cremation Charlottesville, Va.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUL 10 1947 (Date received local registrar) (b) Jr. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10 year 1947 hour 12 minute 05 A.M.

21. I hereby certify that I attended the deceased from June 7, 1947, 1947, to July 10, 1947, that I last saw her alive on 9 p.m. on July 9, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Due to: Hypertension	
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) Place 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 Malone Grand M.D. (M. D. or other)

Address 607 N. Grand Blvd. Date signed 7-10-47

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.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....3575.....

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.