

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29796**

**FILED SEP 3 1947**

Registration District No. ....

Primary Registration District No. **3069**

Registrar's No. **1511**

1. PLACE OF DEATH:

(a) County **St. Louis**  
 (b) City or town **Richmond Heights**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **St. Mary's Hospital**  
(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 **Dent** **33**  
 (c) City or town **Salem**  
(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.....

3. (a) PRINT FULL NAME

**Ronald Joseph Mounce**

3. (b) If veteran,

**No**

3. (c) Social Security No.

**None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Child**  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased **August 30 1946**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**0 10 10** hr. min.

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

10. Usual occupation **Child**

11. Industry or business.....

12. Name **Warren Cobbs**  
 13. Birthplace **Salem Missouri**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Lydia Mounce**  
 15. Birthplace **Salem Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ethel Hammond**  
 (b) Address **Salem, Mo.**  
 17. (a) **Burial** (b) Date thereof **7-12-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Salem, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**  
 (b) Address **4700 Washington Blvd.**  
 19. (a) **7-13-47** (b) **Carol R. Hoppe**  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **10**  
 year **1947** hour **5** minute **10** P. M.

21. I hereby certify that I attended the deceased from **July 7 1947** to **July 10 1947**  
 that I last saw him alive on **July 10 1947**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia**  
 Duration **4 days**

Due to **74a**

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: **Hepatosplenomegaly, generalized lymphadenopathy, toxic splenitis, enlarged Thyroid**  
 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.....  
 Signature **Wm H. Jordan** M. D. or other **St. D**  
 Address **St. Mary's Hospital**  
 Date signed **7/11/47**

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.