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. 32969
90536

FILED OCT 4 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Barnes Hospital (Specify whether
In this community 16 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Marion
(c) City or town Salem
(If outside city or town limits, write "RURAL")
(d) Street No. 627 North Broadway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Satterthwaite Ora Edwin
3. (b) If veteran, name war Unknown
3. (c) Social Security No. 707-03-9385

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ollie Grace Satterthwaite
6. (c) Age of husband or wife if 56 years
7. Birth date of deceased March (Month) 1 (Day) 1890 (Year)

8. AGE: Years 57 Months 6 Days 26 36 If less than one day hr. min.

9. Birthplace Brownstown (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Railway Carman
11. Industry or business C&E.I. R. R.
MOTHER FATHER
12. Name Jacob Satterthwaite
13. Birthplace Unknown (City, town, or county) Scotland (State or foreign country)
14. Maiden name Lavina Savern
15. Birthplace Brownstown (City, town, or county) Illinois (State or foreign country)
16. (a) Informant Ollie Grace Satterthwaite
(b) Address Salem, Illinois
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-27-47 (Month) (Day) (Year)
(c) Place: burial or cremation Salem, Ill.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) SEP 29 1947 (Date received local registrar) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day 27 year 1947 hour 5 minute 30 A M.
21. I hereby certify that I attended the deceased from Sept 11, 1947 to Sept 27 1947; that I last saw him alive on Sept 27 1947; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Hypertensive cardiovascular disease c̄ cardiac insufficiency
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Cardiac enlargement

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 F R Bradley (M. D. or other)
Address Barnes Hospital Date signed 9/27/47

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 Henry W. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.