

No. 2
1-17-39
5-17-39

FILED OCT 24 1947
Registration District No. **318**

Primary Registration District No. **1003**

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: **Infirmiry Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. **10/31/45 to 10/10/47** Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County..... **o-o-c**

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

(d) Street No. **5800 Arsenal St.** **9**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) **0**

If yes, name country.....

3. (a) PRINT FULL NAME **Mathilda Batte**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased **Oct. 31, 1877**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct, 10** day
year **1947** hour **4** minute **55** M. P

21. I hereby certify that I attended the deceased from **1/1**
19**47** to **10/10** 19**47**
that I last saw her..... alive on **10/10**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	69	11	10hr.min

Immediate cause of death. **Aluminum Congestion 1 day**
Supp. pneumonia 2 yrs
Splenomegaly 3
Arteriosclerosis atherosclerosis 10 yrs

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

Major findings:
Of operations.....

Physician.....

Underline the cause of which death should be charged statistically.

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

10. Usual occupation **Nil**

11. Industry or business.....

12. Name **Henry Hoffman**

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

14. Maiden name **Mathilda ?**

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

16. (a) Informant **City Infirmiry Records**
(b) Address **5800 Arsenal St.**

17. (a) **BURIAL** (b) Date thereof **10-13-1947**
(Burial, cremation, or removal) (Month, Day, Year)

(c) Place: burial or cremation **MEMORIAL PARK**

18. (a) Signature of funeral director **Phas. Katus & Son**
(b) Address **2900 Glasgow**

19. (a) **OCT 13 1947** (b) **J. F. Drelack**
(Date received local registrar) (Registrar's signature)

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..... **0**

23. Signature **J. P. Shorney** (M. D. or other) **0**
Address **5800 Arsenal** Date signed **10-11**

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. 3989

P. O. Address St. Louis, Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. N 02Registration District No. 314Primary Registration District No. 1003Registrar's No. 9447

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:

(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 Mathilda Batte

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
- wid

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

7. Birth date of deceased
- Oct 31
- (Month) (Day) (Year)

8. AGE: Years
- 69
- Months
- 10
- Days
- 10
- (If less than one day) hr. min.

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

10. Usual occupation suppl

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) (Date received local registrar)..... (b)
- J. F. Bredeck
- (Registrar's signature)
- NOV 2 1947

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.....
-
- year
- 1947
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;

that I last saw him/her alive on....., 19.....;

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 sta-
tistically.

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..... (M. D. or other).....

Address..... Date signed.....

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

MOTHER FATHER

S-35486

8-3-00