

FILED DEC 6 1947 318

Registration District No. ....

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. ....

Registrar's No. 10802

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution..... St. Johns Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 6 days  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... Crawford 28  
(c) City or town..... Cook Station  
(If outside city or town limits, write "RURAL")  
(d) Street No..... N.R.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Mary Jane Delcour

3. (b) If veteran, name war..... No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife..... Louis Delcour  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased..... November 22 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 0 1 hr. min.

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

10. Usual occupation..... Housewife

11. Industry or business..... At Home

12. Name..... Michael Mills

13. Birthplace..... Unknown Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name..... Unknown

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

16. (a) Informant..... Mary Norris

(b) Address..... Riverview Gardens

17. (a) Burial (b) Date thereof..... 11/24/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Salem, Missouri

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

(b) Address..... 4700 Washington Blvd.,

19. (a) NOV 24 1947 (b) J. F. Bredesch  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 23  
year 1947 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 20th  
1947, to Nov 23 1947.  
that I last saw her alive on Nov 22 1947.  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Cerebral hemorrhage.

Due to..... Sensitivity of aorta  
Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

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?..... (e) Means of injury.....

23. Signature..... Lem Delcour (M. D. or other) ml  
Address..... 821 1/2 N. Broadway Date signed 11-24-47

Duration

40 days

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

*Henry A. 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.