No. 2
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 15 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14925

Registration District No. 317 — Primary Registration District No. 3070 — Registrar's No. 1123

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

1. PLACE OF DEATH:

(a) County: St Louis

(b) City or town: Webster Groves (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 230 E Jackson (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): 6 momths

2. USUAL RESIDENCE OF DECEASED:

(a) State: Ills. (b) County: Madison

(c) City or town: Collinsville (If outside city or town limits, write "RURAL")

(d) Street No.: 435 O'Farrel St., (If rural, give location)

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

If yes, name country .....

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3. (a) PRINT FULL NAME: Mathilda Nearen

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: Wm. Nearen

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

7. Birth date of deceased: Sept (Month) 20- (Day) 1875 (Year)

8. AGE: Years 72 | Months 7 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace: Collinsville, Ills., (City, town, or county) (State or foreign country)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: Charles Kreider
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Catherine Christof
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Chas. Kreider
(b) Address: 230 East Jackson Webster Groves, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof: 5/4/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Collinsville Ills

18. (a) Signature of funeral director: Geo M Schweppe
(b) Address: Collimsville, Ills.

19. (a) 5-4-48 (Date received local registrar) (b) Cecil A Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1948 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from Feb. 16, 1948, to May 2, 1948 that I last saw her alive on May 1, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Gall Bladder — Duration: 6 Month

Due to: 46 f

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) 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: Arthur W Westray (M. D. ~~or other~~)

Address: Webster Groves Mo Date signed: 5-2-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

OCT 16 1948

JUL 7 1949

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 Geo. M. Schnepper

Licensed Embalmer No. 1598

P. O. Address Collinsville, Ill.

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.