

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24934**
Registrar's No. **1825**

Registration District No. **317**

Primary Registration District No. **2002**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town University City
(c) Name of hospital or institution:
6254 Olive St. Road /
(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 Mo. (b) County St. Louis 96
(c) City or town University City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6254 Olive St. Road 5
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Filla.
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,** 2 divorced Widowed
6. (b) Name of husband or wife John C. Filla **6. (c) Age of husband or wife if** alive _____ years
7. Birth date of deceased April 20, 1860.
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 30
year 1948 hour 9.00 minute A.M. M.
21. I hereby certify that I attended the deceased from July 5, 1948 to July 29, 1948
that I last saw her alive on July 29, 1948
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
88 2 10 hr. min.

Immediate cause of death
1 Cerebral Hemorrhage 2 days
2 Cav. Myocarditis and
Myocardial degeneration D.K.
3 Atherosclerosis D.K.
4 Carcinoma right jaw D.K.
and mouth
Other conditions _____ (Include pregnancy within 3 months of death) 450

9. Birthplace Washington, Missouri. (City, town, or county) (State or foreign country)
10. Usual occupation Retired

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Andrwe Max
13. Birthplace Poland 4 (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Poland 4 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Constantine Filla
(b) Address 6254 Olive St. Road
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 2, 1948
(Month) (Day) (Year)
(c) Place: burial or cremation Clover Bottom, Mo.
18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.
19. (a) 2-30-48 (Date received local registrar) (b) Constantine Filla (Registrar's signature)

While at work? _____ (Specify type of place)
Means of injury 0
23. Signature John A. Rogers (M. D. or other) 7/30/48
Address 1693 Delmar Blvd Date signed 7/30/48

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

Dr. John A. Rogers
6693 Delmar Blvd.,
1--5 P.M. CA. 2101.

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.....

Anthony Bonn....., Registered Apprentice No. 102
working under my personal supervision.

Signed.....
Alfred F. Dredel
Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamb Ave.,

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.