

0-47
-39
3908

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED AUG 23 1948
Registration District No. **318**

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **27561**
Registrar's No. **7065**

Primary Registration District No. _____

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:
3327A St. Vincent Av
(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 _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3327A St. Vincent Av
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ESTELLE BUGH
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex FE. / 5. Color or race W.
6. (b) Name of husband or wife Oceola Bugh 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JAN 11 1878
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 9
year 1948 hour 8 minute 30 PM.
21. I hereby certify that I attended the deceased from 7 1948 to Aug 9 1948
that I last saw her alive on Aug 9 1948
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Congestive heart failure

8. AGE: Years 70 Months 6 Days 29
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

9. Birthplace ST. LOUIS (City, town, or county) MO. (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business OWN

PHYSICIAN
Underline the cause to 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? _____

MOTHER FATHER
12. Name JAMES KEANE
13. Birthplace CANADA (City, town, or county) (State or foreign country)
14. Maiden name CATHERINE McDONALD
15. Birthplace MISSISSIPPI (City, town, or county) (State or foreign country)

16. (a) Informant Oceola K. Bugh
(b) Address 3327A St. Vincent Av
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug 12 - 48
(Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director E. J. Schauer
(b) Address 3125 Lafayette Av.
19. (a) AUG 12 1948 (Date received local registrar) (b) J. Bredsch (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature Nyrtu Skouri (M. D. or other) _____
Address Metropolis Ky Date signed 8/9/48

(Licensed Embalmer's Statement on Reverse Side)

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

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

Joe Vallmer

Licensed Embalmer No.

4014

P. O. Address

3125 Polynesian

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.