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

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED AUG 28 1948
318
Registration District No. _____

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003
Primary Registration District No. _____

State File No. **27587**
Registrar's No. **7142**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Dora J. Chrest
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 Married
6. (b) Name of husband or wife Thomas Chrest
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Jan. 10, 1887
(Month) (Day) (Year)

8. AGE:
Years 61 Months 17 Days 3
If less than one day hr. ____ min. ____

9. Birthplace Florissant Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business --
12. Name W. H. Mueller
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Pohlmann
15. Birthplace Florissant Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Chrest
(b) Address Florissant, Mo.
17. (a) Burial Burial **(b) Date thereof** 8/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Black Jack, Mo.
18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson Mo.
19. (a) AUG 14 1948 **(b)** J. B. Bredel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Florissant
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 2
(If rural, give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 13
year 1948 hour 3 minute 15 A. M.

21. I hereby certify that I attended the deceased from Aug 7, 1948 to Aug 13, 1948
that I last saw her alive on Aug 12, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of sigmoid colon
Due to Anemia - Secondary from gradual loss of blood.
Due to H/o

Other conditions (Include pregnancy within 3 months of death) H/o
Major findings:
Of operations none
Of autopsy none
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?
While at work? --- (Specify type of place) (e) Means of injury ---
23. Signature W. H. Mueller (M. D. or other) M.D.
Address Ferguson Mo. **Date signed** 8/13/48

JAN 29 1951

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. 2973

P. O. Address Herguson, 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.