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#89713
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 24 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

31504

State File No. _____
Registrar's No. 8120

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4562 St. Louis Ave.
(If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MARY VON OEHSEN
Mary Von Oehsen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15th
year 1948 hour 6 minute 00 A. M.
21. I hereby certify that I attended the deceased from 9/3/48
_____ 19____ to Sept. 15th 1948
that I last saw her alive on Sept. 15th 1948
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank Von Oehsen 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Nov. 13th. 1895
(Month) (Day) (Year)

Immediate cause of death Metastatic brain tumor
Duration _____

8. AGE: Years Months Days If less than one day
52 10 2 _____ hr. _____ min.

Due to Carcinoma of the Uterus
Due to _____

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife

Major findings: Of operations _____

11. Industry or business _____

MOTHER FATHER

12. Name Michael Kavanaugh
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Jordan
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

Of autopsy _____

16. (a) Informant Frank Von Oehsen
(b) Address 4562 St. Louis, Ave.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof 9/18/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Sullivan Funeral Dir.
(b) Address 2849 North Euclid Ave.

While at work? _____ (Specify type of place) (e) Means of injury _____

19. (a) SEP 16 1948 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

23. Signature 1515 Lafayette (M. D. or other) _____
Address _____ Date 9/23/48

rule

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 *Robert L. Brinkman*

Licensed Embalmer No. *3553*

P. O. Address.....

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.