

No. 30-47
10-47
5-17-39
I 3908

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33818

FILED NOV 6 1948

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 216

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Josephs Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 Days
(Specify whether in this community 20 Yrs years, months or days)

3: (a) PRINT FULL NAME Eleanore E. Bridges

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

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

7. Birth date of deceased: April 7, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

61 6 23 hr. min.

9. Birthplace Chicago Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Oscar Soderberg

13. Birthplace Sweden
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Young

15. Birthplace Boston Mass.
(City, town, or county) (State or foreign country)

16. (a) Informant Mabel Whittemore

(b) Address 3486 St. Jochium Land

17. (a) Eva Burial Ill (b) Date thereof 10/2/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evanston Ill

18. (a) Signature of funeral director Collier Funeral Home

(b) Address 10123 St. Charles Rd.

19. (a) 11-2-48 (b) Frankie Hauweler
(Date received local registrar) (Registrar's signature) 294

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Ann
(If outside city or town limits, write "RURAL")

(d) Street No. 10221 St. Katherine Lane
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1948 hour 7 minute 5 M.

21. I hereby certify that I attended the deceased from Sept, 1947, to October 30, 1948;
that I last saw her alive on Oct 30, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart disease
hypertension

Due to _____

Due to _____

Other conditions hypertension eye kidney
(Include pregnancy within 3 months of death)

Major findings: hypertension
Of operations _____
Of autopsy none

Duration 5yr 10yr

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 _____

Signature Chas B Vatterth (M. D. or other) MD

Address 10300 St Charles Rd Date signed 10/30/48

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

MOTHER FATHER

Date Filed NOV 5 1948
District File Number _____

District Health Officer No. 9,

RECEIVED
DEC 7 1948

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 10123 St. Charles

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.