No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 30 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 34477
Registrar's No. 9142

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 6640 Marquette Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)
In this community 15 Yrs.

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. 6640 Marquette
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Elsie N. Michael
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 M
6. (b) Name of husband or wife Dr. Vernon Michael
6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased June 30, 1903 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
45	3	20	hr. min.

9. Birthplace French Village, (City, town, or county) Illinois (State or foreign country)
10. Usual occupation At Home
11. Industry or business —
MOTHER FATHER
12. Name Gustav Nicol
13. Birthplace Freeberg, (City, town, or county) Illinois (State or foreign country)
14. Maiden name Mary Tribout
15. Birthplace Belleville, (City, town, or county) Illinois (State or foreign country)
16. (a) Informant Dr. Verone E. Michael
(b) Address 6640 Marquette
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/48 (Month) (Day) (Year)
(c) Place: burial or cremation Holy Cross Luth. Cem. Collinsville, Ill.
18. (a) Signature of funeral director BEIDERWIEDEN F.H.INC.
(b) Address 1936 St. Louis Avenue
19. (a) OCT 22 1948 (Date received local registrar) (b) J B Fasaten (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 20th year 1948 hour 8: minute 50 P. M.
21. I hereby certify that I attended the deceased from 4 21 1948 to Oct 20 1948 that I last saw her alive on July 30 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Rheumatic Heart Disease	
Mitral Stenosis & Insuff.	Unk.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy —	

PHYSICIAN
Underline the cause of 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? 0
While at work? (Specify type of place) (e) Means of injury
23. Signature Lebuh L Warner (M.D. or other)
Address Paul Brown Blf Ill Date signed Oct 21-48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

Dr. Henry Cooper
Paul Brown Bldg.
11:00 - 3:00

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 Neal Paulson

Licensed Embalmer No. 414

P. O. Address 1936 St Louis 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.