

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis County  
(b) City or town CHAFFAN  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 DAYS  
In this community 42 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis Co.  
(c) City or town Kirkwood  
(If outside city or town limits, write "RURAL")  
(d) Street No. 400 Rose Hill  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 1  
year 1948 hour 9 minute 0 A. M.  
21. I hereby certify that I attended the deceased from SEPT.  
15, 1948 to OCT. 1, 1948;  
that I last saw her alive on OCT. 1, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Shock + vascular collapse  
Carcinoma of Stomach  
Due to E. Metastasis  
Arteriosclerotic Heart  
Due to Disease

Other conditions  
(Include pregnancy within 3 months of death) 46 lb  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 John W. Greig (M. D. or other) \_\_\_\_\_  
Address 606 Brentwood Blvd Date signed 10/1/48

3: (a) PRINT FULL NAME MAE COLLINS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife CHARLES 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 12, 1869  
(Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 19 If less than one day hr. min.

9. Birthplace BENTON HARBOR MICH.  
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business NONE

12. Name PHILLIP HERBERT

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

14. Maiden name JANE STEWART

15. Birthplace NEW YORK  
(City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORD

(b) Address St. Louis County Hospital

17. (a) Burial (b) Date thereof 10/4/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Peak Hill Cemetery

18. (a) Signature of funeral director Louis H. Popp, Inc.

(b) Address 131 N. Agony Dr. Brentwood Mo

19. (a) 10-1-48 (b) John W. Greig  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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 Peter B. DuRouillet

Licensed Embalmer No. 3691

P. O. Address: Richmond Heights, Va

**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.**