

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38230

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

State File No. _____

FILED NOV 24 1948

318

Primary Registration District No. _____

1005

Registrar's No. 9922

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:
3121 LEMP
 (If not in hospital or institution, write street number or location)
 (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. 3121 LEMP
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ANNE PAUK-HIGGINS

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-01-1535

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 JAN. 28 1902
 (Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation CASHIER

11. Industry or business RESTAURANT

MOTHER FATHER { 12. Name FRED LEAVITT

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

14. Maiden name FRIEDA FLORY (City, town, or county) (State or foreign country)

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

16. (a) Informant JEANETT PAUK

(b) Address 314 S. ELGIN, TULSA, OKLA.

17. (a) CREMATION (b) Date thereof NOV. 16 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CHAPEL

18. (a) Signature of funeral director Thos Kutie & Son

(b) Address 2906 GRAVOIS ST. LOUIS MO

19. (a) NOV 16 1948 (b) J. B. Foster
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13
 year 1948 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from February 16th
1946 to November 13th 1948;
 that I last saw her alive on November 13th 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure due to Respiratory paralysis Duration One week

Due to Atrophic lateral Sclerosis 8 yrs.

Due to _____

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

Major findings: _____ Of operations _____

Of autopsy No Autopsy

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? _____

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

23. Signature Dr. J. L. Adershall (M. D. or other) _____
 Address 3121 Lemp Drive Date signed 11/14/48

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

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..... *Harold C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Harris*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See
Registrar's No. 9922

Registration District No. 318 Primary Registration District No. 1003

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME Anne P. Higgins

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 Wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Jan 28 (Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 9 (Less than one day) hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....
17. (a) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (b) J. B. Lasater (Registrar's signature)
(Date received local registrar) DEC 3 1946

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 22 Day 1946 Year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other)

Date signed.....

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

SUPPLEMENTARY

S-38230

5-38230