

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9504
Registrar's No. 2987

Registration District No. 791 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution None City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 5021 Cabanne Ave
years, months or days)

3. (a) PRINT FULL NAME Ida May Oursler

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 Divorced

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years About 49 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 13. Birthplace Unknown (City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Coroner's Office
(b) Address _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1 1940 (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers Cemetery

18. (a) Signature of funeral director Petz Brothers
(b) Address 3029 Lafayette Ave

19. (a) MAR 30 1940 (Date received local registrar) (b) J. F. Beduch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")
(d) Street No. 5021 Cabanne Ave
(If rural, give location) ***
(e) If foreign born, how long in U. S. A.? _____ years.

No Physician in Attendance

20. DATE OF DEATH: Month 28th day March
year 1940 hour 1:00 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

Pneumococcal Meningitis
Purulent Otitis Media
Pneumococcal Emphysema

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) (Means of injury)

23. Signature Joseph D. [unclear] (Date of operation) _____
Address _____ Date signed _____

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 Frank J. Luens

Licensed Embalmer No. 2245

P. O. Address St. Louis Mo.

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, above space should be left blank.