

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20031

State File No.

Registrar's No.

791

JUL 17 1940
1003

4979

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

St. Louis, Mo.

- (a) County _____
 - (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
 - (c) Name of hospital or institution:
2531 Chester Place.
(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)

3. (a) PRINT FULL NAME: **Florence Sondhaus 532**

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 **Married**

6. (b) Name of husband or wife **Edw. Sondhaus** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **June 4, 1896**
(Month) (Day) (Year)

8. AGE: Years **44** Months **0** Days **2** If less than one day hr. min.

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Maurice Shea**

13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary K. Shea**

15. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Florence Sondhaus**
(b) Address **2531 Chester Place.**

17. (a) **Burial** (b) Date thereof **6/8/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Sullivan Und. Co.,**

(b) Address **2849 N. Euclid Ave.,**

19. (a) **JUN 7 1940** (b) _____
(Date received local registration)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo.** (b) County _____
- (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
- (d) Street No. **2531 Chester Place.**
(If rural, give location)
- (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **6**
year **1940** hour **11:50** minute **A** M.

21. I hereby certify that I attended the deceased from **April 12**, 19**40**, to **June 6**, 19**40**, that I last saw him alive on **June 6**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **metastatic carcinoma** Duration **6 mo**

Due to **Primary Carcinoma uterus** **1 year**

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

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 **Arthur S. Swales** (M. D. or other) **MD**
Address **2102 University St** Date signed **6/21/40**

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

MOTHER FATHER

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 _____

Albert Mayfield

Licensed Embalmer No. _____

P. O. Address _____

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.