

FILED SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27030**
6926
Registrar's No.

Registration District No. **791**

Primary Registration District No. **1003**

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:
St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days.**
In this community **Life.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **MAIE BUMB** **SID**

8. (b) If veteran, name war _____ 8. (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 **Lawence** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug. 7th 1883**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 0 7 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **At Home.**

12. Name **Alfred St Cyre**

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

14. Maiden name **Agnes Hortize**

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

16. (a) Informant **Margaret Smith**
(b) Address **922 Park Ave.**

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

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

18. (a) Signature of funeral director **Thos. Curtis**

(b) Address **2906 Gravois Ave.**

19. (a) **AUG 18 1940** (b) **J. T. Bredbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis.** **23**
(If outside city or town limits, write "RURAL")
(d) Street No. **922 Park Ave.**
(If rural, give location)
(e). If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **14**
year **1940** hour **7²⁰** minute **A** M.

21. I hereby certify that I attended the deceased from **Aug. 6th, 1940** to **Aug. 14th, 1940**
that I last saw her alive on **Aug. 14th, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Thrombus of Pulmonary Artery** Duration **10 mo**

Due to **122**

Due to _____

Other conditions **Strangulated Hernia** **3 da**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **Herniaotomy 8/10/40**
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 **Dr. H. H. Walters** (M. D. or other)
Address **3608 So. Grand Blvd.** Date signed **8/15/40**

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

2004
—
MILLER BEERY
7800 W. 10th ST.

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

Leo Budde

Registered Apprentice No.

working under my personal supervision.

Signed

Leo Budde

Licensed Embalmer No. *3989*

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.