

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

SEP 25 1940 STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27092

State File No. \_\_\_\_\_

6988

Registration District No. 791 Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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: BARNES HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME ELMIRA VERLE SEE ATD

3. (b) If veteran, name war NO 3. (c) Social Security No. na

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ELMER 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased APRIL 6 1896  
 (Month) (Day) (Year)

8. AGE: Years 44 Months 4 Days 10 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 HOME

12. Name FRED BHRMESTER

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

14. Maiden name EMILY HARRS

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

16. (a) Informant's own signature Elmira See.

(b) Address 309 W. Ripa

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

(c) Place: burial or cremation MNT HOPE CEM.

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

(b) Address 7128 ...

19. (a) AUG 19 1940 (b) \_\_\_\_\_  
 (Date received from registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town LeMay NR  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 309 W. Ripa  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16  
 year 1940 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 30, 1940, to August 16, 1940  
 that I last saw her alive on August 16, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death cardiac decompensation  
Rheumatic heart disease

Duration

20 yrs

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 F. R. Bradley (M. D. or other) \_\_\_\_\_  
 Address BARNES HOSPITAL Date signed \_\_\_\_\_

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

*J. C. Fendler*  
.....  
Licensed Embalmer No. *925*

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.**