

FILED SEP 25 1940
791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27304

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **7200**

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:
3229 Tennyson Sq. 2)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **none**
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME **Emilie Becker** 260
8. (b) If veteran, name war **no** 8. (c) Social Security No. **no**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **Feb. 19, 1868**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	6	6	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Phillip Maag** 9

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

14. Maiden name **Emilie Stennagalt**

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

16. (a) Informant **Joseph F. Becker**

(b) Address **3203 Byron Pl.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8-28-1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Lukes Cem.**

18. (a) Signature of funeral director **Jay B. Smith**

(b) Address **7456 Manchester**

19. (a) **AUG 28 1940** (b) **J.F. Beecher** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0 **Missouri**
(a) State _____ (b) County _____
(c) City or town **St. Louis** 3
(If outside city or town limits, write "RURAL")
(d) Street No. **3229 Tennyson Sq.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG.** day **25**
year **1940** hour **5** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **Mar 30th**
1940, to **Aug 25**, 1940,
that I last saw her alive on **Aug 25th**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic interstitial nephritis** 1 yr.
Duration

Due to _____

Due to _____ 131

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 **Pierre M. Brossard** M. D. or other _____

Address **3300 Cambridge** Date signed _____

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 *J. P. Burgess*

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.