

No. 2
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17-35
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29657

Registration District No. 784

Primary Registration District No. 270

Registrar's No. 1463

1. PLACE OF DEATH:

(a) County Wagoner

(b) City or town Pine Bluff
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6825 NAT-BRIDGE RD. 2
(If not in hospital or institution, give street number or location)

(d) Length of stay in hospital or institution 12
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Wagoner

(c) City or town Pine Bluff
(If outside city or town limits, write "RURAL")

(d) Street No. 6825 NAT. BRIDGE RD.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME NELLIE STAED. 330

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

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

6. (b) Name of husband or wife JOHN STAED 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased MAY 15 1871
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name BRYAN TICHE

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

14. Maiden name UNKN

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

16. (a) Informant Grace Sullivan

(b) Address 1217 HAMILTON AVE

17. (a) BURIAL (b) Date thereof 8-3-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director L. M. Muller

(b) Address 5165 DELMAR BLVD

19. (a) AUG - 2 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1st year 1940 hour 12:00 minute Noon M.

21. I hereby certify that I attended the deceased from March 8, 1939 to July 28 1940; that I last saw her alive on July 28 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Senile Dementia</u>	<u>?</u>
<u>Fracture Neck Right Femur</u>	<u>3 yrs.</u>
<u>Secondary: Uremia and Coma, Heat</u>	<u>2 "</u>
<u>Prostration</u>	<u>1 wk.</u>
<u>Died in Mother of Good Counsel Home</u>	
Other conditions <u>"Home of Incurables"</u> (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings: None

Of operations None

Of autopsy None

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) No

(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 [Signature] (M. D. or other) M. D.

Address 3718 Jennings Rd., Pine Lawn Date signed 8-2-40

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

1948
99

Dr Tiernan
Pine Lawn
2 PM

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.....

John Ketter
Licensed Embalmer No. 3880

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, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

29657

State File No. 1463-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Primary Registration District No. Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mother of Good Council
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Nellie Stead
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

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

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

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name _____
13. Birthplace. (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 8-2-40 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug. day 1 - 1940
year _____ hour _____ minute _____ 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 Cardio-renal vascular disease
Duration 131

Due to Fract. neck of Femur

Other conditions Neat prostration
(Include pregnancy within 3 months of death)

Major findings: Prostration due to extreme heat and being in a terminal state before.
Of operations _____
Of autopsy From history, tripped over rug in home 2 or 3 years before entering Home of the incurables.

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? _____
(Specify type of place) _____ (e) Means of injury _____

23. Signature P. J. Truena (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL COPY

