U. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21

4

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33008

State File No.

Registration District No. 773 | Primary Registration District No. 60184 | Registrar's No. 163

1. PLACE OF DEATH:
(a) County St. Francois St Francois
(b) City or town Near Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 mos.
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DEECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4427 Norman
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MARY S. CERULO
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 Dominic
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 14 1894 (Month) (Day) (Year)
8. AGE: Years 46 Months 3 Days 1 If less than one day hr. min.
9. Birthplace St. Louis, Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation Housewife. 1
11. Industry or business ?
MOTHER FATHER
12. Name John Schredenski
13. Birthplace Poland (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Price
15. Birthplace Poland (City, town, or county) (State or foreign country)
16. (a) Informant Hospital Records
(b) Address State Hospital #4 Farmington Mo
17. (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof 9-18-40 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Baumgartner Brothers
(b) Address 2504 Woodson Rd Overland Mo.
19. (a) Sept 15-40 (Date received local registrar) (b) B. J. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15
year 1940 hour 1:00 minute M.
21. I hereby certify that I attended the deceased from 14, 1940 to Sept. 1, 19..;
that I last saw her alive on Sept 15, 19..;
and that death occurred on the date and hour stated above.
Immediate cause of death Hy Sarcoma
left clavicle with Recurrence
of the left side.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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) Suicide
(b) Date of occurrence Sept. 15-1940
(c) Where did injury occur? State Hospital #4 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? N/A (Specify type of place)
While at work? (e) Means of injury
23. Signature Jos Diemer (M. D. or other) Coroner.
Address Flat River Mo. Date signed 9-15-40

(Licensed Embalmer's Statement on Reverse Side)

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 Earl F. Hillerman

Licensed Embalmer No. 3501

P. O. Address Overland 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.