

No. 2
13-40
17-39
X29139

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36379

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1943

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
9435 Chester Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Margaret Ames

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Late Matthew Ames

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

7. Birth date of deceased Nov. 1st 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>11</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation Housework at home

11. Industry or business _____

MOTHER FATHER {

12. Name Unknown Harney

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Johanna R. Palm

(b) Address 9435 Chester Ave.

17. (a) Burial (b) Date thereof 10-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuar
(Specify type of place)

(b) Address 4228 So. Kingshighway Blvd.

19. (a) OCT 14 1940 (b) R. Meyer M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 9435 Chester Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13th
year 1940 hour 3 minute A.M. M.

21. I hereby certify that I attended the deceased from Nov 2nd
1932 to Oct. 13 1940
that I last saw her alive on Oct 12th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 6 yrs

Due to _____

Due to 93C

Other conditions Arterial Sclerosis 10 yrs.
(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 Arnold H. Warger (M. D. or other) MD
Address 2900 St Charles Date signed 10/14/40

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

8920
Dr. Wurzer
St. Chas Rd.

WA: 1548 2-4

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 *Remond K. Lohman*

Licensed Embalmer No. *3395*

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.