

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE MISSOURI STATE BOARD OF HEALTH  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

36402  
State File No.

Registration District No. 784 Primary Registration District No. 111 Registrar's No. 1967

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Mary's Hospital  
(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 Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4972 Odell Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULLNAME Margaret Linn Splan  
(b) If veteran, name war None (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 16th  
year 1940 hour 1:30 minute P.M. M.  
21. I hereby certify that I attended the deceased from 10-7-40  
1940 to 10-16 1940  
that I last saw her alive on 10-16 1940  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive 39 years  
7. Birth date of deceased Aug. 22nd 1905  
(Month) (Day) (Year)

Immediate cause of death Grossia from acute nephritis  
Due to Hypertension & urinary suppurative  
Due to pregnancy  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
35 1 24 hr. min.  
9. Birthplace Springfield Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_

Major findings:  
Of operations Ante partum pregnancy 7 1/2 months  
Of autopsy Acute nephritis  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
{ 12. Name John Peter Schmidt  
13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
{ 14. Maiden name Cora LaVert  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
16. (a) Informant Peter Splan  
(b) Address 4972 Odell Ave.  
17. (a) Cremation (b) Date thereof 10-19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mo. Crematory  
18. (a) Signature of funeral director Kriegshauser Mortuaries  
(b) Address 4228 So. Kingshighway Blvd.  
19. (a) OCT 17 1940 (b) J.R. Meyer M.D.  
(Received in accordance with law) (Registrar's signature)

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 Joselyn M. Splan (M. D. or other) \_\_\_\_\_  
Address 4972 Odell Ave. Date signed 10-17-40

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

146-971

Ca. 3898  
Inactive  
Dr. J. B. Jones

**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 Edwin A. McQuinn  
Licensed Embalmer No. 3024  
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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36402  
Registrar's No. 1967-

Registration District No. .... Primary Registration District No. ....

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

1. PLACE OF DEATH:  
(a) County St. Louis Rech. S.T.S.  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution:  
(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)

3. (a) PRINT FULL NAME Margaret L. Splan  
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 M

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

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

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

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

19. (a) 10-17-40 (b) J.R. Mey. J.D.A.P.P. (Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month Oct Day 16 Year 40  
hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis from pregnancy

Due to pregnancy

Due to 149 N

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Cesarian Section done 10-5-40-normal Of autopsy findings

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 Jos. M. Ryck (M. D. or other) Address 6420 Clayton Date signed

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

