

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2100

I. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Normandy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Council Home
Mother of Good 6825 Nat. Bridge Rd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 years
(Specify whether years, months or days) 2

8. (a) PRINT FULL NAME Amelia Tappe

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

4. Sex Female 6. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased March 5 TH 1857
(Month) (Day) (Year)

8. AGE: Years _____ Months 8 mo Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Seamstress

11. Industry or business _____

12. Name Not Known

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant REV. J. Mubely

(b) Address 3519 N 14 Th Str

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 Th 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Galvary Cemetery

18. (a) Signature of funeral director Edward Frank

(b) Address 3516 N 14 Th Str

19. (a) NOV 8 1940 (Date received local health officer) (b) R. Meyer M.D. & Pt. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3324 Blair Avenue
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 6th
year 1940 hour 7:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 15, 1929, to Nov. 5, 1940;
that I last saw her alive on Nov. 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Generalized Arteriosclerosis, Generalized Anasarca, Gangrene of feet, Senile Dementia, Senile Myocarditis, Secondary: Cardiac Decompensation, Uremia, Uremic Coma
Died in Home of Incurables

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

Major findings: Of operations None
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(b) Date of occurrence --
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) (a) Means of injury _____

23. Signature Dr. J. B. Jennings (M. D. or other) 1
Address 3718 Jennings Rd., Pine Lawn Date signed 11-7-40

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

93 R

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 Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 732 Zema

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39766

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registrar's No. 2100

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Normandy
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Amelia Tazape

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 _____

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 _____ h. _____ 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 _____

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) 11-8-40 (b) _____ (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 Nov. 6 - 40
year _____ hour _____ minute _____ M.

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

Immediate cause of death Chr. Ren. Arteriosclerosis
Progressive
Highly symptomatic
Due to Chronic Interstitial Nephritis
Uremic - uremic coma
Also - _____

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

Major findings: Of operations _____

Of autopsy _____ 131

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

Address _____ Date signed _____

SUPPLEMENTARY

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

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

1940
S-39766