

FILED FEB 14 1941
Registration District No. 184

Primary Registration District No. 117

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

1. PLACE OF DEATH:

(a) County ST LOUIS

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

(c) Name of hospital or institution:
506 CHERRY
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 1 YR. 3 Mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS

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

(d) Street No. 506 CHERRY ST.
(If rural, give location)

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

3. (a) PRINT FULL NAME SARAH GERTRUDE WALDRON

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 5. 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 JULY-30-?
(Month) (Day) (Year)

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

about 82 - - - - - yr. - - - - - min.

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name DANIEL WALDRON

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

14. Maiden name GERTRUDE ANN ACKERMAN

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

16. (a) Informant Helen Watter

(b) Address 506 CHERRY ST.

17. (a) BURIAL (b) Date thereof JAN-9-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation COLORADO-SPINGS, CO.

18. (a) Signature of funeral director Barker and Co

(b) Address WEBSTER GROVES

19. (a) JAN 8 - 1941 (b) L. K. Newman
(Date received local registrar) (Registrar's signature)

Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7th
year 1941 hour 7:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 1940 to Jan. 7, 1941;
that I last saw her alive on Jan. 7, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency?
(Cardio-Vascular Renal Disease)

Due to _____

Other conditions Visceral Carcinoma
(Include pregnancy within 5 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) _____

(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 L. K. Newman (M. D. or other) _____

Address Webster Groves Mo Date signed 1/8/41

9/2
7
4
0

41

55

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

Orvin B. Lang

Licensed Embalmer No. *1584*

P. O. Address

Webster Groves

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. 4368
Registrar's No. 48

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
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(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 Sarah J. Waldron

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 _____ 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) _____ 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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) 1-8-41 (b) J.R. Meyer M.D.P.H. (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan. day 7 year 1941 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 Myocardial Infarct.
Due to Cor. Vasc. Ren. Dis.

Due to _____
Other conditions (Include pregnancy within 3 months of death) Visceral carcinoma

Major findings: Cholera
Of operations _____
Of autopsy many

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) _____
(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 J. R. Meyer (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

