

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 25 1941  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16296

State File No. \_\_\_\_\_

3814

Registrar's No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City 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 000  
(c) City or town St. Louis 617  
(If outside city or town limits, write "RURAL")  
(d) Street No. 533I Wells Ave.  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd  
year 1941 hour 7:45 minute \_\_\_\_\_ P. 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 \_\_\_\_\_  
Fracture of Left Femur; Arteriosclerosis; suffered when deceased slipped  
Due to and fell to the kitchen floor at  
her home 533I Wells Ave., on April  
9th, 1941, at about 9:00 A.M.

Other conditions \_\_\_\_\_  
(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) Accident  
(b) Date of occurrence April 8, 1941

(c) Where did injury occur? St. Louis, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In Home

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 3

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 5/16/41

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

3. (a) PRINT FULL NAME Theresia Cameron

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles Cameron 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 12 1870 1941

8. AGE: Years 71 Months I Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Peter Schneider  
13. Birthplace Germany (City, town, or county) (State or foreign country)

{ 14. Maiden name Rose Moeck  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Agnes Miller

(b) Address 533I Wells Ave.

17. (a) Burial (b) Date thereof 5-6-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cem.

18. (a) Signature of funeral director Drehmann Harral

(b) Address 1905 N. Union Blvd.

19. (a) MAY 5 1941 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**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.....

*Warren A. Carve*  
Licensed Embalmer No. *3534*

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.**