No. 2
-4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED SEP 17 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

14003

State File No. 26858

Registration District No. 7791

Primary Registration District No.

Registrar's No. 6650

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

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: Deaconess 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 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

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

(d) Street No. 1216 Woodland Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

096
08
N.R.3

3. (a) PRINT FULL NAME Mary R. DeVos

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 Married

6. (b) Name of husband or wife Francis DeVos

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased July (Month) 4th (Day) 1902 (Year)

8. AGE: Years 39 | Months 1 | Days 9 | If less than one day ___ hr. ___ min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John F. Towell
13. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Mary A. Cox
15. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Francis DeVos
(b) Address 1216 Woodland Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-41 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Peter & Paul

18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 So. Kingshighway Blvd.

19. (a) AUG 14 1941 (Date received local registrar) (b) J. H. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 13th year 1941 hour 8:05 minute P.m. M.

21. I hereby certify that I attended the deceased from Aug 13, 1941, to Aug 13, 1941; that I last saw her alive on Aug 13 1941 —, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory failure	
Due to Massive hemorrhage of pons and medulla due to toxemia of Pregnancy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy As above + Petechial hemorrhages of liver	

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

23. Signature Matthew W. Weis MD (M. D. or other)
Address 634 No Grand Ave Date signed 8/14/41

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Primary Registration District No..... Registrar's No.....

1. PLACE OF DEATH:
(a) County.....
(b) City or town.....
(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..... (Specify whether years, months or days)
In this community.....

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.

3. (a) FULL NAME PRINT

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

4. Sex..... 5. Color or race..... 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 ..... hr. ..... min.

9. Birthplace.....

10. Usual occupation.....
11. Industry or business.....
12. Birthplace..... (State or foreign country), Registered Apprentice No.....
13. Maiden name.....
14. Birthplace..... (City or town) (County) (State or foreign country)
15. Address.....
(Buried, cremated, or removed)
(Place) (Date) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... 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..... Duration

Due to.....

Due to.....

Other conditions.....

Major 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? ..... (Specify type of place)

23. Signature..... (M. D. or other) ..... Address.....

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 working under my personal supervision.

Signed Edwin R. Hermann 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.

(Licensed Embalmer's Statement on Reverse Side)

FOR USE OF LYDING BLACK INK—NEW LEGAL RECORD

No. 2
-9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26859

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 6650

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:
(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

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary A. DeVos
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
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
			hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Mar-5-1942 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 13 year 1941 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 — Duration
Due to Toxemia of pregnancy
Due to No delivery - fœtus remained in-utero.
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 144d
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.