

S. No. 2
1-1-4-41
5-17-39
P1 X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36046**

FILLED OCT 28 1941

Registration District No. **202**

Primary Registration District No. **202**

Registrar's No. **2063**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
2624 Edgar Ave.
(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 Ethel Gertrude Xenos

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 Married

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

7. Birth date of deceased July 30 1891
(Month) (Day) (Year)

8. AGE: Years 50 Months 2 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Mason Co. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Melvin Jacobs

{ 13. Birthplace Mason Co. Illinois
(City, town, or county) (State or foreign country)

{ 14. Maiden name Mary Unknown

{ 15. Birthplace Mason Co. Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant William Xenos Sr.

(b) Address 2624 Edgar Ave.

17. (a) Burial (b) Date thereof 10/10/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT 9 - 1941 (b) C. H. Mc Carrah, Md
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 2624 Edgar Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7
year 1941 hour 3 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Jan 1 1941 to Oct 7 1941
that I last saw him alive on Oct 6 1941
and that death occurred on the date and hour stated above.

Immediate cause of death uraemia Duration 1 yr.

Due to Diffuse cystic disease of both kidneys

Due to _____

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

Major findings: Of operations 133/2

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? _____

While at work? _____
(Specify type of place) (e) Means of injury 0

23. Signature C. E. Sterling M.D. (M. D. or other) _____
Address 2050 No. 48th Rd Date signed 10-8-41

(Licensed Embalmer's Statement on Reverse Side) St Louis Co. Mo

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 Guy W Wilkinson

Licensed Embalmer No. 3575

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.