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No. 2
5-42
5-17-39
X32873

FILED OCT 6 1942
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. 7909

318
1003
Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 Days
(Specify whether
In this community 4 Months
years, months or days)

3. (a) PRINT FULL NAME Geraldine Butcher
3. (b) If veteran, name war No
3. (c) Social Security No. Unknown

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive Single
7. Birth date of deceased April 24, 1920
(Month) (Day) (Year)

8. AGE: Years 22 Months 4 Days 8
If less than one day hr. min.

9. Birthplace Weston West Va.
(City, town, or county) (State or foreign country)

10. Usual occupation Waitress

11. Industry or business Restaurant

MOTHER FATHER

12. Name Samuel Butcher

13. Birthplace West Va.
(City, town, or county) (State or foreign country)

14. Maiden name Vista Flanigan

15. Birthplace West Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Morrison
(b) Address St. Louis City Hospital.

17. (a) Burial (b) Date thereof 9-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. J. White
(b) Address City Hospital, Mo.

19. (a) SEP 23 1942 (b) J. F. Beedeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 17
(c) City or town St. Louis 925
(If outside city or town limits, write "RURAL")
(d) Street No. 510 Elm St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 1,
year 1942 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from August 17, 1942 to September 1, 1942;
that I last saw her alive on September 1, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death
Bilateral for advanced pulmonary tuberculosis

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

PHYSICIAN
Major findings:
Of operations
Of autopsy as above

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. M. Hensen (M. D. or other) 9/1/42
Address 1515 Lafayette Avenue Date signed

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

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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 with the above constitutes grounds for revocation of license.)

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