

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1941**

FILED MAR 10 1943
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4660 Korte Place /
(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 **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4660 Korte Place**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Pauline C. Connor**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**

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

7. Birth date of deceased **Aug. 28, 1860**
(Month) (Day) (Year)

8. AGE: Years **82** Months **5** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Herman Lampe**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Sophia Abel**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Helen Connor**

(b) Address **4660 Korte Place**

17. (a) **Burial** (b) Date thereof **Mar. 1, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Bromschwig Und. Co.**

(b) Address **4746 West Florissant**

19. (a) **FEB 27 1943** (b) **J. J. Medeck**
(Date received from Registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **FEB** day **25th**
year **1943** hour **12:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **Sept 1942** to **FEB 25 1943**
that I last saw her alive on **FEB 25 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Myocarditis** ?
Chronic Arthritis ?
Arterio Sclerosis ?

Other conditions (Include pregnancy within 3 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? _____
(Specify type of place)

While at work _____ (e) Means of injury _____
23. Signature **Pauline C. Connor** (M, D, or other) **MD**
Address **4356 Marne** Date signed **2/24/43**

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.....

E. W. Wilkins

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.