

S. No. 2  
4-5-42  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15582

State File No. ....

Registrar's No. ....

76  
00

FILED MAY 6 1943  
Registration District No. 17

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Koch

(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 2 yrs 25 days (Specify whether)

In this community Same  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

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

(d) Street No. 2119 ANGELICA (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Mary Frances Wade

3. (b) If veteran, name war -

3. (c) Social Security No. Mo. 117

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 3 Divorced

6. (b) Name of husband or wife Joseph Pickett 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased May 6 1913  
(Month) (Day) (Year)

8. AGE: Years 29 Months 0 Days 27 If less than one day hr. min.

9. Birthplace Lawrence Mass  
(City, town, or county) (State or foreign country)

10. Usual occupation Waitress

11. Industry or business Hospital

MOTHER FATHER { 12. Name John Wade

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

14. Maiden name Sophie OTT

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

16. (a) Informant Koch Hospital Record

(b) Address Koch Hospital

17. (a) Removal (b) Date thereof 4-12-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence Mass.

18. (a) Signature of funeral director Wm. E. Maxwell

(b) Address 1926 Allen

19. APR 13 1943 (b) C. J. Mc...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9  
year 1943 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from 3-14 - 1941 to 4-9 - 1943  
that I last saw h. et. alive on 4-9-43, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration Dec 1940?

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy yes 1361

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 .....

23. Signature Paul Murphy (M. D. or other) C  
Address Koch 140 Date signed 4-9-43

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 me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed W. B. Moydell

Licensed Embalmer No. 1467

P. O. Address 1926 Allen ave

**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.**