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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19942

JUN 19 1943 818

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 5374

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 3 Days
(Specify whether _____)

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. 3015a South Jefferson Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martha Province

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month June day 11, year 1943 hour 8:40 minute A. M.

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

21. I hereby certify that I attended the deceased from June 9, 1943, to June 11, 1943 that I last saw her alive on June 11, 1943 and that death occurred on the date and hour stated above.

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

Immediate cause of death Anterior chronic heart disease Duration _____

7. Birth date of deceased November 11 1851
(Month) (Day) (Year)

8. AGE: Years 91 Months 7 Days 0 If less than one day hr. _____ min. _____

Due to _____
Due to _____

9. Birthplace Bowersville Ohio
(City, town, or county) (State or foreign country)

Other conditions late latent syphilis
(Include pregnancy within 3 months of death)

10. Usual occupation Housework

Major findings: Disseminated arthritis Hypertrophic arthritis PHYSICIAN _____

11. Industry or business _____

12. Name David Means

Of autopsy Refused

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

14. Maiden name Mary Bowers

15. Birthplace Bowersville Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Lee Province

(b) Address Flat River, Missouri

17. (a) Burial (b) Date thereof 6/13/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) JUN 11 1943 (b) J. F. Beedick
(Date received local registration) (Registrar's signature)

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) (2) Means of injury _____

23. Signature Frank U. Hinkley M.D. or other U.S.
Address 1515 Lafayette Ave. Date signed 8/11/43

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

MOTHER FATHER

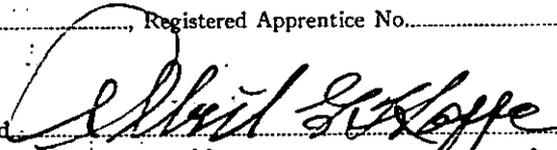
STATEMENT BY LICENSED EMBALMER

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..... 2971

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.