

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39881

FILED JAN 4 1944 318

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 11660

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: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 9/6

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

(d) Street No. 42 Ridgemoor Dr.
(If rural, give location) NR.

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

If yes, name country _____

3. (a) PRINT FULL NAME Bertha Hauer Greenwood

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10 to 24
year 1943 hour 2 minute 30 A.M.

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

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

7. Birth date of deceased March 11 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 10, 1943, to December 24, 1943;
that I last saw her alive on December 24, 1943;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>9</u>	<u>13</u>	hr. _____ min. _____

Immediate cause of death Cardiac respiratory failure 10 days

Due to Cardiac decompensation 1 1/2 years

9. Birthplace Rochester Ind.
(City, town, or county) (State or foreign country)

Due to Hypertensive cardiovascular disease

10. Usual occupation at home

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

11. Industry or business _____

12. Name unknown

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

Major findings: 93

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Arthur Finn

(b) Address 42 Ridgemoor Dr.

17. (a) Burial (b) Date thereof 12-26-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

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? _____

18. (a) Signature of funeral director Herman Kindsch

(b) Address 5216 Delmar Blvd.

19. (a) DEC 26 1943 (b) J. F. Budesch
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury 0

18. Signature FR Bradley (M. D. or better)

Address BARNES HOSPITAL Date signed 12/24/43

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.....

William Herons

Licensed Embalmer No.....

4319

P.O. Address.....

5216 Delmar

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.