S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

12542

State File No.

FILED MAY 2 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3840

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 Days (Specify whether years, months or days)
In this community 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000 17
(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")
(d) Street No. 6000 N. Broadway 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rose Mary Behring
3. (b) If veteran, name war ---------
3. (c) Social Security No. 488-09-6025
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Fred Behring
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased June (Month) 2 (Day) 1881 (Year)

8. AGE: Years 62 Months 10 Days 21 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
MOTHER FATHER
12. Name Manuel Oribe
13. Birthplace Spain (City, town, or county) (State or foreign country)
14. Maiden name Inez Styles
15. Birthplace Kentucky (City, town, or county) (State or foreign country)
16. (a) Informant Fred Behring
(b) Address 6000 N. Broadway
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Bellfontain Cem.
18. (a) Signature of funeral director Diedrich F. Home
(b) Address 8319 Halls Ferry Rd.
19. (a) APR 25 1944 (Date received in registrar's office) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1944 hour 8:30 minute P. M.
21. I hereby certify that I attended the deceased from 11/23 19 43, to 4/23 19 44 that I last saw her alive on 4/23 19 44 and that death occurred on the date and hour stated above.

Immediate cause of death (1) Toxemia + peritonitis. (2) Myocardial failure — Duration
Due to (1) Gangrene of abdominal wall following a partial resection for a strangulated hernia.
Due to
Other conditions (Include pregnancy within 3 months of death) No (1) Myocarditis, Chronic
Major findings: Of operations (2) Hypertension (3) angina pectoris
Of autopsy (4) Gangrenous ileum

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) no
(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 William D. Maurer M.D. (M. D. or other)
Address 3623 Fair Date signed 4/25/44

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Hoffer.

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.