

No. 2  
5-43  
-17-39  
X36671

24281  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19058

FILED JUN 20 1944  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003 Registrar's No. 5428

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) 0  
(d) Length of stay: In hospital or institution 2 mos-28 days  
(Specify whether \_\_\_\_\_)  
In this community 75-4-9  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
Missouri  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") no  
(d) Street No. 2313 Cass ave.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Julia Erickson  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 15th  
year 1944 hour 8 minute 45A. M.  
21. I hereby certify that I attended the deceased from March 18th  
19 44 to June 15th 19 44  
that I last saw her alive on June 15th 19 44  
and that death occurred on the date and hour stated above.

4. Sex female  
5. Color or race white  
6. (a) Single, widowed, married, divorced widow  
(b) Name of husband or wife Gustav  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
6 1869  
Feb. (Month) (Day) (Year)

Immediate cause of death Carcinoma of the lung.  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
75 4 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy refused.

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business \_\_\_\_\_

12. Name Thomas Shannon

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Julia Carten

15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Lang  
(b) Address 308 W. Koeln

17. (a) burial (b) Date thereof 6-19-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director M. Schumacher  
(b) Address 3013 Meramec

19. (a) JUN 18 1944 (b) J. F. Bruesel  
(Date received by Registrar) (Registrar's signature)

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 Wesley Wade Date signed 6/15/44  
Address 1515 Lafayette

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

600  
2019

---

---

**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 Francis A. Williams

Licensed Embalmer No. 3565

P. O. Address St Louis

**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.**