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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22405

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1395

1. PLACE OF DEATH:

(a) County St. Louis,
(b) City or town Richmo nd Heights,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3423A Crittenden 9
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Martha Bach,

3. (b) If veteran, name war None
3. (c) Social Security No. none

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February 20th (Month) (Day) Unknown (Year)

8. AGE: Years about 65 | Months UNK. | Days UNK. | If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
10. Usual occupation Seemstress
11. Industry or business self

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Robert Holmes
(b) Address 4931 Lindell Blvd.
17. (a) burail (Burial, cremation, or removal) (b) Date thereof 6/28/44 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.
18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Lindell Blvd.
19. (a) JUN 28 1944 (Date received local registrar) (b) C. G. McGavran (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 26
year 1944 hour 11:00 minute A M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Spinal anaesthesia. | Duration

Due to Surgical removal of carcinoma of the bowel.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 4.6
Of autopsy Yes.

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) Accident.
(b) Date of occurrence June 26, 1944
(c) Where did injury occur? St. Mary's Hospital (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Hospital
(Specify type of place)
While at work? (e) Means of injury

23. Signature Carmel T. Fischer (M. D. or other)
Address Clayton, Mo. 6-27-44 Date signed

(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 Neville B. Grohwitter

Licensed Embalmer No. 3696

P. O. Address 4161 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.