

S. No. 2  
OM-5-43  
v. 5-17-39  
I X3687

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 16 1945 318

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. \_\_\_\_\_  
Registrar's No. 962

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4211 McPherson Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) 30 years

3. (a) PRINT FULL NAME Margaret Bryan  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.O.  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan. 6th., 1891  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>0</u>	<u>24</u>	hr. min.

9. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housemaid

11. Industry or business \_\_\_\_\_  
12. Name Thomas Bryan  
13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Stephens  
15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Kathryn Bryan  
(b) Address 4211 McPherson Ave.  
17. (a) Burial (b) Date thereof 2-1-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Galvary

18. (a) Signature of funeral director Arthur J. Donnell  
(b) Address 3840 Lindell Blvd.  
19. (a) JAN 31 1945 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4211 McPherson Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 30th.,  
year 1945 hour 5 minute a. M.  
21. I hereby certify that I attended the deceased from March 14, 1944 to Jan 30, 1945  
that I last saw her alive on Jan 23, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Enteritis (The)  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 F. F. Bergmann M. D. or other M.D.  
Address 3220 Washington Date signed 1/30/45

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

MOTHER, FATHER

2-1-1

**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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address. 3840 Lindell

**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.