S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4563

State File No.

FILED FEB 16 1945 318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 1124

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:
Cabanne Nursing Home 11
(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)
In this community Life

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Mo (b) County 18
(c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
(d) Street No. 5564 Cabanne
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alice Waugh
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 25 (Day) 1863 (Year)
8. AGE: Years 79 Months 4 Days 6 If less than one day hr. min.
9. Birthplace St. Louis (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Housework
11. Industry or business at Home
FATHER
12. Name David Waugh
13. Birthplace Ireland (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name ary E Koop
15. Birthplace Tenn (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Mary Mc Cormick
(b) Address 3533 Lafayett Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof feb 5 45 (Month) (Day) (Year)
(c) Place: burial or cremation Bellfontian Cemetery
18. (a) Signature of funeral director KRIEGSHAUSER
(b) Address 4228 So. Kingshighway
19. (a) FEB 5 1945 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1 year 1945 hour 11 PM minute M.
21. I hereby certify that I attended the deceased from 3-3, 1943 to 2-1, 1945 and that I last saw he alive on 2-1, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis chronic	
Due to Hodgkins Dis	
Due to	
Other conditions (Include pregnancy within 3 months of death) —	
Major findings: Of operations None	
Of autopsy None	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Philip Schwartz (M. D. or other)
Address 1703 N Grand Date signed 2-3-45

(Licensed Embalmer's Statement on Reverse Side)

Dr Phil Schuck
Grand & Lafayett

1124

1124

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 Edwin D. McDermott

Licensed Embalmer No. 3024

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.