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FILED DEC 22 1947

Registration District No. 377

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 10672A

Registrar's No. 2529

1. PLACE OF DEATH:

(a) County... **St. Louis**
(b) City or town... **Manchester**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution... **Pine Crest Nursing Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... **12 years**
(Specify whether years, months or days)
In this community... **12 years**

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME: **Kate Neff**

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex... **Female** 5. Color or race... **White** 6. (a) Single, widowed, married, divorced... **Widowed**
6. (b) Name of husband or wife... **Mathias** 6. (c) Age of husband or wife if alive... _____ years
7. Birth date of deceased... **February 12, 1872**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 **1** **3** _____ hr. _____ min.

9. Birthplace... **Hungary**
(City, town, or county) (State or foreign country)

10. Usual occupation... **Housewife**

11. Industry or business... **Home**

12. Name... **Unavailable**

13. Birthplace... **Hungary**
(City, town, or county) (State or foreign country)

14. Maiden name... **Unavailable**

15. Birthplace... **Hungary**
(City, town, or county) (State or foreign country)

16. (a) Informant... **Mrs. Magdalena Gille**

(b) Address... **740 No. Euclid Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof... **3/19/45**
(Month) (Day) (Year)

(c) Place: burial or cremation... **Lakewood Park Cem.**

18. (a) Signature of funeral director... **Shanklin-Kron Funeral**
(b) Address... **4911 Washington Blvd.**

19. (a) **12-11-47** (Date received local registrar) (b) **Gene J. Stark** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **15**
year... **1945** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw her alive on **March 15**, 19 **45**,
and that death occurred on the date and hour stated above.

Immediate cause of death... **Chr. Myo-carditis**

Due to **Arterio-Sclerosis**

Due to _____

*Other conditions... (Include pregnancy within 3 months of death)

Major findings:
Of operations... _____

Of autopsy... _____

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... _____

Signature... **R. St. Janssen** (M. D. or other)

Address... **Manchester, Mo.** Date signed... **4-2-47**

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING UNFADING BLACK INK—MAY BE RECORDED

JAN 8 1948

DEC 29 1947

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.....

..... Licensed Embalmer No.....

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.