

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18000

State File No. 2

FILED JUN 7 1945  
Registration District No. 3719

Primary Registration District No. 6076

Registrar's No. 1000

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Overland Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Sarah J Berliner Nursing Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4  
(Specify whether years, months or days)

In this community 4  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4959 Lindenwood Ave  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Annan Gavolen

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Andrew

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 1 1869  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>5</u>	<u>20</u>	hr. min.

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

10. Usual occupation Housework

11. Industry or business at Home

12. Name John White

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

14. Maiden name Katherine Godfrey

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

16. (a) Informant Katherine Lohrum

(b) Address 4959 Lindenwood Ave

17. (a) Burial (b) Date thereof 4 25 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) APR 25 1945 (b) E. B. H. Bourson, MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21  
year 1945 hour 7.55 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 16  
\_\_\_\_\_ 1945 to Apr. 21 \_\_\_\_\_ 1945  
that I last saw her alive on April 21 \_\_\_\_\_ 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchical pneumonia

Due to Senile Hypertension

Due to 107

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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 Ray A. Walker (M. D. or other) \_\_\_\_\_  
Address 2438 Woodson Date signed 4/27/45

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

16  
33  
1

DE VALLEYS  
2438 Woodson Rd  
2 to 4

**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. Mc Dermott*

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.**