

P.S. No. 2  
FORM-5-42  
Rev. 5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18230

State File No. ....

Registrar's No. 950

Registration District No. 317

Primary Registration District No. 6076

600  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
6148 Gambleton Place  
(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.....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Wellston  
(If outside city or town limits, write "RURAL")

(d) Street No. 6148 Gambleton Place  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Susan Rice

(b) If veteran, name war No

(c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17  
year 1945 hour 8.45 minute P.M. M.

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married

7. Birth date of deceased July 29, 1865.  
(Month) (Day) (Year)

8. (b) Name of husband or wife Henry Rice 6. (c) Age of husband or wife if alive 77 years

21. I hereby certify that I attended the deceased from March 1, 1945 to present date., 19...;  
that I last saw h. er alive on 4-17-45, 19...;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>8</u>	<u>18</u>	hr. min.

Immediate cause of death.....

Due to Chronic myocarditis. one year.

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

10. Usual occupation Housewife

Due to.....

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

11. Industry or business.....

12. Name George Steinsultz

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

14. Maiden name Margaret Schaffer

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

Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Blanche Halter  
(b) Address 6148 Gambleton Place

17. (a) Burial (b) Date thereof April 20/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.

18. (a) Signature of funeral director Jos. W. Clark  
(b) Address 1125 Hodiament Ave.

19. (a) APR 20 1945 (b) E. E. H. Cannon  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature Paul Over (M. D. or other) M.D.  
Address 1194 Hodiament Date signed 4-18-45

Dr. O.O. White  
1194 Hodiament Ave.,  
CA. 8755.

JUN 5 1945

JUN 8 1945

**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..... *Joe W. Clark* .....  
Licensed Embalmer No. 16611 .....  
P. O. Address 1125 Hodiament Ave., .....

**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.**