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M-5-43  
7-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28876

FILED SEP 15 1945

Registration District No. 2002 Primary Registration District No. 2002 Registrar's No. 2202

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
7648 Canton 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)

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

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 7649 Canton Ave.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Mary T. Anderson

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 Widow

6. (b) Name of husband or wife George F. Anderson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 2, 1867  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>78</u>	<u>2</u>	<u>7</u>	hr. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10  
year 1945 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from May 4 45  
1945 to Sept. 10 1945

that I last saw her alive on Sept 9 45  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Carcinoma of Gallbladder</u>	<u>2 yrs</u>
<u>Chronic Myocarditis</u>	<u>5 yrs</u>

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

9. Birthplace St. Louis Mo. (1)  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name John Kane

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Dont Know

15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Hollocher

(b) Address 7649 Canton Ave.

17. (a) Burial (b) Date thereof 9-12-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) 9-12-45 (b) C. B. M. Harvan MD  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature A. M. Wurser (M. D. or other) M.D.  
Address 8900 St. Charles Rd. Date signed 9/10/45

*Dr. C. H. Winger*  
*890 St. Andrews*  
*2-4*  
*12th St*

**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.