S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29307

FILED SEP 28 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8091

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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: Booth Memorial Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hr. 30 min. (Specify whether years, months or days)

In this community 4 hr. 30 min.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 500

(c) City or town St. Louis 17 14 (If outside city or town limits, write "RURAL")

(d) Street No. 6203 Arthur 9 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Susan Rae Pence

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased September (Month) 15 (Day), 1945 (Year)

8. AGE: Years — Months — Days — If less than one day 4 hr. 30 min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Raymond Pence
13. Birthplace Washington Park Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dorothy Antle
15. Birthplace Tarpon Springs Florida (City, town, or county) (State or foreign country)

16. (a) Informant (mother) Dorothy Pence

(b) Address 6203 Arthur

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

(c) Place: burial or cremation KANE, ILL.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 17 1945 (Date received local registrar) (b) J. Predeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15 year 1945 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from 4:20 PM 9/15, 1945 to 9:10 PM 9/15, 1945; that I last saw her alive on 7:00 PM 9-15, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage into cerebellum	4 hrs
Due to difficult delivery (Version & extraction)	
Due to Generally contracted Pelvis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy no	

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 Victor L. Gould (M. D. or other) MD

Address 28119 Watson Date signed 9/15/45

(Licensed Embalmer's Statement on Reverse Side)

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.