

S. No. 2
OM-543
v. 5-17-39
I X36671

35100

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

State File No.

FILED NOV 23 1945
318

STANDARD CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

1003

Registrar's No.

9809

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
(Specify whether years, months or days)

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. 1220 Park Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARCIA BULLOCK

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White / 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased January 9th 1894
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER { 12. Name Thomas Rollo
13. Birthplace Scotland 4
(City, town, or county) (State or foreign country)
14. Maiden name Melvina Smith
15. Birthplace Illinois /
(City, town, or county) (State or foreign country)

16. (a) Informant William Bullock Husband
(b) Address 1220 Park Ave

17. (a) Burial (b) Date thereof Nov 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Peetz Bros

(b) Address 3029 Lafayette Ave

19. (a) NOV 13 1945 (b) J. F. Bradeef
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11th
year 1945 hour 9:00 minute A M.
21. I hereby certify that I attended the deceased from 10/23/45
19 to 11/11/45 19 ;
that I last saw her alive on 11/11/45 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage-Lenticulo-Strate
Due to artery

Due to Arteriosclerosis
Other conditions 83
(Include pregnancy within 8 months of death)

Major findings: Of operations _____
Of autopsy _____
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 J. F. Bradeef 11/13/45
Address 1515 Lafayette Date signed _____

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

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 *Francis J. Durmo*

Licensed Embalmer No. *2245*

P. O. Address *St. Louis, Mo*

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.