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M-5-43  
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

35708

FILED NOV 19 1945

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9724

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

1. PLACE OF DEATH:

(a) County CITY HOSPITAL

(b) City or town ST. LOUIS MO

(c) Name of hospital or institution: CITY HOSPITAL  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Louise Park

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 MARRIED

6. (b) Name of husband or wife LEO

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

7. Birth date of deceased Oct. 23 1902  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

43 0 16 hr. min.

9. Birthplace ST. LOUIS, MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

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

12. Name ADOLPH KINGLER

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

14. Maiden name BERNADINE CARMIZING

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

16. (a) Informant LEO PARK

(b) Address 3139 NEBRASKA

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

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director J. P. Redick

(b) Address 2906 GRAYSON

19. (a) NOV 9 1945 (b) J. P. Redick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 3139 NEBRASKA  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9<sup>th</sup>  
year 1945 hour 1 minute 05 AM

21. I hereby certify that I attended the deceased from Oct. 6 1945 to Nov 9 1945  
that I last saw her alive on Nov. 9 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation Duration 6 hrs.

Due to Carcinoma of uterus with metastases 3 yrs.

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

Other conditions (Include pregnancy within 3 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 Cornealia E. Motley (M. D. number) \_\_\_\_\_  
Address 1515 Lafayette Date signed 11-9-45

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:

working under my personal supervision.

Registered Apprentice No.

Signed

*David Van Fossan*

Licensed Embalmer No.

*4242*

P. O. Address

*2906 Harris 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.**