DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7318

FILED MAR 7 1946

Registration District No. 918 Primary Registration District No. 1003 Registrar's No. 1830

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

1. PLACE OF DEATH:

(a) County

(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:
5300 Bancroft 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 5300 Bancroft Ave 149
(If rural, give location) 10

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

If yes, name country

3. (a) PRINT FULL NAME Addie Challis

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 Widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 4th (Day) 1867 (Year)

8. AGE: Years 78 Months 11 Days 18 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Mc Gown

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

MOTHER 14. Maiden name Rebecca

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

16. (a) Informant Mrs Thomas W. Challis

(b) Address 5300 Bancroft Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Drehmann-Harral U. Co

(b) Address 1905 Union Blvd St. Louis Mo

19. (a) FEB 25 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby day 22 year 1946 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from ~~Feb 22~~ Nov 4 1940 to Feb 22 1946 that I last saw her alive on Feb 21 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart disease since Nov 1940

Due to Diabetes Mellitus Nov 1940

Due to Arterosclerosis with hypertension Nov 1940

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Leo F. Gerald (M. D. or other)

Address 6677 Delmar Date signed Feb 22, 1946

(Licensed Embalmer's Statement on Reverse Side)

Ni R.P. Fitzgerald
6677 Nelson
2 = 4

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 Warren A. Carver

Licensed Embalmer No. 3534

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.

No. 2B
—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. M 22

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1830

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Addie Challis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 4 (Day) 1866 (Year)

8. AGE: Years 78 Months 11 Days 18 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MAR 13 1946

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 22
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

7318