

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 31 1946 **STANDARD CERTIFICATE OF DEATH**

18851
State File No. _____
Registrar's No. **4669**

Registration District No. _____ Primary Registration District No. **1003**

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:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether years, months or days) 28 years

3. (a) PRINT FULL NAME Margaret Louise Duwe
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 Married
6. (b) Name of husband or wife E. H. Duwe 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Jan. 21 1892
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 2
If less than one day _____ hr. _____ min.

9. Birthplace Steger, Ills.
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

11. Industry or business
12. Name Demling 4
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Louise Crutner
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant E. H. Duwe
(b) Address 2005 Bellevue, Maplewood
17. (a) removal (b) Date thereof 5/25/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Homewood, Ills

18. (a) Signature of funeral director Alexander Sons
(b) Address 6175 Delmar
19. (a) MAY 24 1946 J. F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Maplewood
(If outside city or town limits, write "RURAL")
(d) Street No. 2005 Bellevue
(If rural, give location) NR 3
(e) Citizen of foreign country? No. (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month MAY day 23
year 1946 hour 9: minute 30 A. M.
21. I hereby certify that I attended the deceased from 1931 to May 23 1946
that I last saw h. er alive on May 23 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia 18 day
hypertension 590 +
hypertensive heart dis 3 11 +
Due to Fibroid tuberculosis of upper 18 yr.
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: Of operations 13
Of autopsy ascabov
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 _____ (c) Means of injury _____
23. Signature Louise Duwe (M. D. or other) _____
Address 450 Bellevue Date signed 5/25/46

*Do Sale
4500 Olive 1-5*

AUG 19 1949

JAN 15 1953

MAY 26 1954

CERTIFICATE

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 *Thomas R. Penwik*

Licensed Embalmer No. *3793*

P. O. Address *6175 Delmar*

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.

Dear Dr. Smith: -

I am very sorry that I was stupid enough to report pulmonary tuberculosis as cause of death in above.

Cause of death was a wide spread broncho-pneumonia, non-tuberculous. I should, of course, have underlined this. Autopsy disclosed an old fibrous process in the right apex. I felt that this, too, should be included. Shall I fill out the enclosed?

18351

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

4669

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town _____
 (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 **Margaret L Dawe**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____
 7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year) _____

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____ Duration _____

Due to Bronchial Pneumonia

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

18351