

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. **5506**

Registration District No. **III 31804**

Primary Registration District No.

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

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. **Life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MARY ARCHAMBO**

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 **W**

6. (b) Name of husband or wife **?** 6. (c) Age of husband or wife if alive **14** years (Day) (Year)

7. Birth date of deceased **Sept 14 1873**
(Month) (Day) (Year)

8. AGE: Years **72** Months **9** Days **5** If less than one day hr. min.

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

10. Usual occupation **at home**

11. Industry or business **=**

MOTHER FATHER { 12. Name **Marion Carnack**

13. Birthplace **9**

14. Maiden name **Unknown**

15. Birthplace **0**

16. (a) Informant **Mrs. Konnie Meyer**

(b) Address **2613 Weber St.**

17. (a) **Burial** (b) Date thereof **6-22-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus**

18. (a) Signature of funeral director **Benderwick**

(b) Address **1936 St. Louis Ave.**

19. (a) **JUN 21 1946** (b) **J. F. Bredeck**
(Date and time of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**

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

(d) Street No. **2509** **Marden Lane** **9**
(If rural, give location)

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

If yes, name country **=**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** 19 **19** day **20** year **1946** hour **8:20** minute **P** M.

21. I hereby certify that I attended the deceased from **May 20** to **June 19**, 19 **46**

or **June 19**, 19 **46**

that I last saw h **or** alive on **June 19**, 19 **46**

and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive and arteriosclerotic Cardiovascular Disease**

Due to **92**

Other conditions **adenoma of thyroid**
(Include pregnancy within 5 months of death)

Non-toxic

Major findings: Of operations **none**

Of autopsy **Same**

PHYSICIAN **Arthur R. Dalton M.D.**

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? **0**

While at work? **0** (Specify type of place) (c) Means of injury

23. Signature **Arthur R. Dalton** M. D. or other **MD**

Address **1515 Lafayette Avenue** Date signed **6/20/46**

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.....

Neal H. Paulson

Licensed Embalmer No.

4114

P. O. Address.....

1936 St. Louis 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.