

DEPARTMENT OF COMMERCE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

21812

State File No. \_\_\_\_\_

5515

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

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:  
**6431a Wade Ave**  
(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 **Mo** (b) County \_\_\_\_\_  
 (c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **6431a Wade Ave**  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Mary Harrison**  
 3. (b) If veteran, name war **No**  
 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **June** day **19** 19**46**  
 year **1946** hour **8.20 PM** minute \_\_\_\_\_ M.

4. Sex **Female** 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **Ambrose**  
 6. (c) Age of husband or wife if alive **7** **1866**  
 7. Birth date of deceased (Month) **July** (Day) **7** (Year) **1866**

21. I hereby certify that I attended the deceased from **June 10**, 19**46**, to **June 19**, 19**46**, that I last saw her alive on **June 19**, 19**46**, and that death occurred on the date and how stated above.

8. AGE: Years **79** Months **11** Days **12** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Hypostatic Pneumonia** Duration **24 hours**

9. Birthplace **St. Louis Mo**  
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Housework**

Other conditions **Chronic Myocarditis**  
(Include pregnancy within 3 months of death)

11. Industry or business **At Home**

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

12. Name **Unknown**

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

14. Maiden name **Mary Conrad**

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

16. (a) Informant **Ambrose Harrison**  
 (b) Address **6431a Wade Ave**

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

(c) Place: burial or cremation **Sunset Burial ark**  
**Kriegshauser**

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 **Vincent F. Townsend** (M. D. or other) **MS**  
 Address **3101 Sulton Ave Maplewood** Date signed **6.20.46**

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

MOTHER FATHER

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**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 Edwin D Mc Dermott

Licensed Embalmer No. 3024

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.**