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

State File No. **31526**
Registrar's No. **77741**

FILED SEP 16 1946
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(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:
1221 Clara
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County o.c.
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 519
(d) Street No. 1221 Clara (If rural, give location) 90
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HARRIET E. BAKER
(b) If veteran, name war _____ (c) Social Security No. 500-16-6711

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 28
year 1946 hour 3: minute 00 A.M.

4. Sex F. 5. Color or race W.
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Clifford C. Sec. 6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased June 23 1862
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 11th 1946 to Sept 6th 1946
and that I last saw her alive on Sept 5th 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>2</u>	<u>13</u>	hr. min.

Immediate cause of death Carcinoma of left mammary gland
Due to _____
Due to 50

Duration 34 years
Physician _____
Underline the cause to which death should be charged statistically.

9. Birthplace New York City, N. Y. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife, Sec.
11. Industry or business Tuscan Chapter O. E. S.

Other conditions Secondary anemias
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

MOTHER, FATHER
12. Name Peter Eager
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Reve
15. Birthplace Unknown (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant F. N. Merwin
(b) Address 1221 Clara
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/9-46 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove

While at work? _____ (Specify type of place)
Means of injury _____
23. Signature Rough Turner (M. D. _____)
Address 1251 Blackstone Date signed Sept 7-1946

18. (a) Signature of funeral director Alexander Sons
(b) Address 6175 Delmar
19. (a) SEP 9 1946 (Date received local registrar) (b) J. Bredack (Registrar's signature)

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. Terwick*

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.