

No. 2
12-45
-17-39
X47070

FILED #6289
SEP 16 1946
Registration District No. **518**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(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 _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Two
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5922 Minnesota ave. 19
(If rural, give location) no 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MARY DESNOYER

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thomas Desnoyer 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased February 16 1885
(Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Unknown Marquette

12. Name _____
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Desnoyer
(b) Address 5922 Minnesota ave.

17. (a) Burial (b) Date thereof Sept. 10-16
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
(b) Address 7814 S. Broadway

19. (a) SEP 9 1946 (b) J. F. Biedeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7th
year 1946 hour 12:10 minute A M.
21. I hereby certify that I attended the deceased from 9/3/46
_____, 19____, to Sept. 7th, 1946;
that I last saw her _____ alive on Sept. 7th, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis from left
coronary artery 3 days

Due to Hypertension 10 years
Due to Pneum

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy Denial

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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? _____

23. Signature Herbert 9/7/46
_____ (Specify type of place) _____ (c) Means of injury _____
_____ (City or town) (County) (State)
Address _____ Date signed _____

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 *Lina C. Hoffmann*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

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.