

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

State File No. **32054**  
Registrar's No. **7598**

**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:  
Barnes Hospital, 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County ST. LOUIS 96

(c) City or town CLAYTON NR2  
(If outside city or town limits, write "RURAL")

(d) Street No. 8227 Tipton Way 3  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Drene Louise Nielson

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 MARRIED

6. (b) Name of husband or wife STEVIE NIELSON 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Oct. 12<sup>th</sup> 1902  
(Month) (Day) (Year)

**8. AGE:** Years 43 Months 10 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name CARL WALL 4

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

14. Maiden name MARGARET DANIELSON

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

16. (a) Informant Stevie Nielson

(b) Address 8227 Tipton Way

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/5/46  
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem.

18. (a) Signature of funeral director Lawrence Mullen

(b) Address 5165 Delmar Blvd

19. (a) SEP 3 1946 (Date received local registrar) (b) J. F. Brudick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 9 day 2 year 1946 hour 1 minute 10 A. M.

21. I hereby certify that I attended the deceased from 8/20/1946 to Sept 2, 1946

that I last saw h. alive on Sept 2, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism Duration \_\_\_\_\_

Due to Thrombophlebitis, post partum 2 1/2 mo.

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

Other conditions 147  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy AS ABOVE

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 0

23. Signature J. R. Bradley (M. D. or D.O.) \_\_\_\_\_  
Address Barnes Hospital Date signed 9/3/46

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

*H. G. Harris*

Licensed Embalmer No.

*3384*

P. O. Address

*St. Louis*

**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.**