No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 2 1946

Registration District No. 4582 518

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 38976

Primary Registration District No. 1003

Registrar's No. 9930

**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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community 2 months
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County

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

(d) Street No. Booth Memorial Hospital
Memorial 3700 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JOYCE H. PISTOLE

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 single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 9th, 1946
(Month) (Day) (Year)

8. AGE: Years | Months 1 | Days 4 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business nil

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

MOTHER
14. Maiden name Mary Lou Pistole
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital

17. (a) ~~(Burial,~~ cremation, ~~or removal)~~ (b) Date thereof 11 21 46
(Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W.T. White
(b) Address City Hospital No 1

19. (a) 11-21-46 (Date received local registrar) (b) J.F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 13th
year 1946 hour 10:45 minute P M.

21. I hereby certify that I attended the deceased from 11/7/46
, 19 , to Nov. 13th , 19 46
that I last saw her alive on Nov. 13th , 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Staphylococcus septicemia

Due to

Due to

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

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Janet Talmadge M.D.
(M.D. or other)

Address 1515 Lafayette Date signed 11/14/46

(Licensed Embalmer's Statement on Reverse Side)

## 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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**