

S. No. 2
M-5-43
7. 5-17-39
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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. 42897

FILED DEC 24 1946
318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10683

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5577 Pershing Avenue
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 5577 Pershing Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: CARRIE ROVEE

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 Leon Rovee 6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12 year 1946 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov. 2, 1946 to 12-12, 1946 that I last saw her alive on 12-12, 1946 and that death occurred on the date and hour stated above.

8. AGE: Years About 72 Months _____ Days _____ If less than one day hr. _____ min. _____

Immediate cause of death coronary occlusion Duration _____

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within 6 months of death)

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

10. Usual occupation At home

Major findings: none

Of operations _____

Of autopsy _____

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

MOTHER FATHER

11. Industry or business _____

12. Name Joseph Baer

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

14. Maiden name Unknown

15. Birthplace Austria
(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 Dr. C. E. Rovee

(b) Address 5327 Pershing

17. (a) Burial (b) Date thereof 12-13-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cem.

While at work? 0 (Specify type of place) (c) Means of injury _____

23. Signature Milton Smith (M. D. or other) _____
Address 308 N. 6th St Date signed 12/12/46

18. (a) Signature of funeral director [Signature]

(b) Address 5216 Delmar Blvd.

19. (a) DEC 13 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

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. Burgess

Licensed Embalmer No.

4029

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.