

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2324**
Registrar's No. **1145**

FILED FEB 10 1947
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.....
 (b) City or town..... ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4441 DELOR
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community..... 5 YEARS
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo (b) County.....
 (c) City or town..... ST LOUIS
(If outside city or town limits, write "RURAL")
 (d) Street No..... 4441 DELOR
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME JUSTINE H. CAREY
 3. (b) If veteran, name war..... NO
 3. (c) Social Security No.....

4. Sex..... FEMALE
 5. Color or race..... WHITE
 6. (a) Single, widowed, married, divorced..... WIDOWED
 6. (b) Name of husband or wife..... JOSEPH M.
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... OCT 5 1901
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>3</u>	<u>27</u>	hr. min.

9. Birthplace..... HUNGARY 4
(City, town, or county) (State or foreign country)

10. Usual occupation..... SECRETARY

11. Industry or business..... PAINT MANUFACTURER

12. Name..... MARTIN ANNAU

13. Birthplace..... HUNGARY 1
(City, town, or county) (State or foreign country)

14. Maiden name..... ELIZABETH SCHORSCH

15. Birthplace..... HUNGARY 4
(City, town, or county) (State or foreign country)

16. (a) Informant..... Justine Carey JR.

(b) Address..... 4441 DELOR

17. (a) BURIAL (b) Date thereof..... 2-4-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... NEW S.S. PETER & PAUL

18. (a) Signature of funeral director..... Cullen & Kelly

(b) Address..... 4386 LINDELL BLVD.

19. (a) FEB 3 1947 (b) J. Bread
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Feb day..... 1
 year..... 1947 hour..... minute.....
 21. I hereby certify that I attended the deceased from..... May 15
 1946 to..... Feb 1 1947
 that I last saw her..... alive on..... Jan 30 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Lympho-sarcoma
with generalized metastases
 Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations..... May 31, 1946 Boston
Lympho-sarcoma
 Of autopsy.....

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)
 (c) Means of injury.....
 23. Signature..... J. M. McLaughlin (M. D. or other)
 Address..... 590 Grand Blvd Date signed..... 2-1-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St. Louis Mo

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.