

No. 2
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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

3014

FILED FEB 10 1947

State File No. _____

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **1150**

1003

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:
2161 Esther
(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
(Specify whether 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. 2161 Esther
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MARGARET BELLE REECE

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 Widowed

6. (b) Name of husband or wife Edward D. Reece

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

7. Birth date of deceased Jan 31 1871
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1947 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 19 - 1947 to Feb. 3rd 1947
that I last saw him alive on Feb 2nd - 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>0</u>	<u>2</u>	hr. _____ min. _____

Immediate cause of death Ch. Myocarditis Indefinite

Due to Cerebral haemorrhage 4 hrs

Due to Arteriosclerosis Indefinite

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

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Wood

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

14. Maiden name Eliza Mackey

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Pauline Schaefer

(b) Address 2161 Esther

17. (a) Removal (b) Date thereof Feb 3 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director C. Hoffmeister Colonial Mort.

(b) Address 6464 Chipmunk St.

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

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? _____

23. Signature C. Wilcox M.D. (M. D. or other) M.D.
Address 3225 Delmar av Date signed 2-3-47

(Licensed Embalmer's Statement on Reverse Side)

St. Louis 9th C.V. Wilcox

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

Dr. C. V. Wilcox
3228 Ivanhoe

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.....

Louis C. Hoffmeister

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 comp the above constitutes grounds for revocation of license.)

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