

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11882

FILED APR 14 1947

State File No. _____

Registration District No. 37

Primary Registration District No. 6076

Registrar's No. 967

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Mueller's Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 4

(d) Street No. 3219 Morganford Rd.
(If rural, give location) 1

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

If yes, name country _____

3. (a) PRINT FULL NAME ELIZABETH D. ARMSTRONG

3. (b) If veteran, name war None

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 William

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Nov. 17 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>4</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Jefferson Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Carl Blumenberg

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth McDaniel

15. Birthplace Franklin Co. Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant William Armstrong

(b) Address 3219 Morganford Rd.

17. (a) Burial (b) Date thereof 4 5 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Kriegshauer Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) 4-7-47 (b) Carl R. Shaffer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1947 hour 7:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from JUNE 1946
_____ 19____, to 1 APRIL 1947
_____ 19____.

that I last saw h. CR alive on 1 APRIL 1947
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC MYO-CARDIIS AND MYO-CARDIAL DEGENERATION.

Due to Chronic Nephritis & ARTERIOSCLEROTIC KIDNEY

Due to _____

Other conditions _____
(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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Dora Armstrong (M. D. or other) M.D.

Address 5430 Dutton Ave Date signed 2 April 47

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

✓
5
4
3
2
1

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 *Erwin M. Bennett*

Licensed Embalmer No. *3024*

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.