

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 7 1947
Registration District No. 377

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Sappington Rd At Lindbergh
(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 Missouri (b) County St. Louis

(c) City or town Sappington
(If outside city or town limits, write "RURAL")

(d) Street No. Sappington Rd At Lindbergh
(If rural, give location)

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

3. (a) PRINT FULL NAME Linda Ann Colby

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 Child

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

7. Birth date of deceased 4/17/1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

| | | | |
|---|----|----|----------|
| 6 | 11 | 13 | hr. min. |
|---|----|----|----------|

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

10. Usual occupation None

11. Industry or business.....

MOTHER FATHER { 12. Name David L. Colby

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

14. Maiden name Marcella Reid

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

16. (a) Informant David L. Colby
(b) Address Sappington Rd At Lindbergh

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

(c) Place: burial or cremation St. Peter & Pauls Cemetery

18. (a) Signature of funeral director Robert J. Ambruster Inc
(b) Address 6633 Clayton Rd

19. (a) 4-3-47 (b) Robert J. Ambruster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st,
year 1947 hour..... minute P M.

21. I hereby certify that I attended the deceased from 4-17
1947 to 4/2/47, 19.....
that I last saw her alive on 3/31/47, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Respiratory failure

Due to.....
Acute leukemia

Due to.....
740

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

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....

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 Peter A. Davis (M. D. or owner)
Address 634 North Grand Ave Date signed 4/2/47

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 Arnold W. Schoene
Licensed Embalmer No. 3864
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.