

FILED SEP 15 1947

Registration District No. 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 29712

Registrar's No. 1871

1. PLACE OF DEATH:

(a) County St. Louis County
 (b) City or town Clayton, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution St. Louis County Hosp. 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether years, months or days) 20 years

3. (a) PRINT FULL NAME

Curran, Laura
 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 6. (c) Age of husband or wife if alive 1 years
 7. Birth date of deceased Feb. 1, 1866
 (Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 28 If less than one day
 hr. min.

9. Birthplace Trenton, Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name Charles Zachary H

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

14. Maiden name Janice Robinson

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

16. (a) Informant Laura Curran

(b) Address Highway 141, Valley Park

17. (a) BURIAL (b) Date thereof 9-1-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cem. Valley Park, Mo.

18. (a) Signature of funeral director Headley Funeral Home

(b) Address Ballwin, Mo.

19. (a) 9-2-47 (b) Gene J. Slapnick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co. 916
 (c) City or town Valley Park 16
 (If outside city or town limits, write "RURAL")
 (d) Street No. Highway 141 0
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29
 year 1947 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from August 26
1947 to August 29, 1947
 that I last saw her alive on August 29, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive HEART FAILURE
 Duration

Due to Arteriosclerotic Cardiovascular Disease

Due to 93d

Other conditions Arteriosclerosis, general
 (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: _____

Underline the cause of 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?..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature R. H. Henders (M. D. or other).....

Address 601 Brentwood Blvd Date signed.....

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.....

Thos. Schaefer

Licensed Embalmer No.....

3066

P. O. Address.....

Lallevia, 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.

Registration District No. 317 Primary Registration District No. 8063

1. PLACE OF DEATH: **ST. LOUIS**
(a) County Clayton
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Laura Curran
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced and
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased set 1
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Stenographer

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug Day 19 Year 1947 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____
Due to _____
Due to _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

Supplemental

S-29712