No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35625

FILED NOV 3 1947 Reg. No. 70478

Registration District No. 340 Primary Registration District No. 1003 Registrar's No. 9612

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital #1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days) In this community

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. 469 WALSH (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MISSOURI LOUISE CROSS
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 MARRIED
6. (b) Name of husband or wife AARON CROSS
6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased August (Month) 24 (Day) 1870 (Year)
8. AGE: Years 77 Months 1 Days 21 If less than one day hr. min.
9. Birthplace DE SOTO (City, town, or county) Mo. (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business
MOTHER FATHER
12. Name JAMES BOLY
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name MALINDA RORIS
15. Birthplace Mo (City, town, or county) (State or foreign country)
16. (a) Informant AARON CROSS
(b) Address 469 WALSH
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-18-47 (Month) (Day) (Year)
(c) Place: burial or cremation ODD FELLOWS CEM
18. (a) Signature of funeral director C. Hoffmeister & Co.
(b) Address 7814 S. Broadway
19. (a) OCT 17 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th year 1947 hour 1:15 minute A M.
21. I hereby certify that I attended the deceased from 10-11-47, 19..., to 10-15-47, 19...; that I last saw her alive on 10-15-47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial Hemorrhage - Right internal capsule
Due to Cerebral Arteriosclerosis & Hypertension Cardiovascular disease
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy Hemorrhage into right ventricle + Right internal capsule

Duration

PHYSICIAN

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 Jaluel W Korkter M.D. (M. D. or other)
Address 1515 Lafayette Date signed 10-15-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.