

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

39392

State File No.

FILED NOV 22 1947

318

1003

Registrar's No.

10257

Registration District No.

Primary Registration District No.

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: 3951 Cottage Ave. /
(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 Nora E. Asinger

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, widow

6. (b) Name of husband or wife John W. Asinger, Sr. 6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased Feb. 5th 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 29 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Vahey

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

14. Maiden name Mary O'Halloran

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

16. (a) Informant Mr. John Asinger, Jr.

(b) Address 3951 Cottage Ave.

17. (a) burial (b) Date thereof 11-27-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,

(b) Address 2849 North Euclid Ave.

19. (a) NOV 6 1947 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

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. 3951 Cottage Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4
year 1947 hour 2:10 PM minute _____ M.

21. I hereby certify that I attended the deceased from July 1933 to 11/4/47 1947
that I last saw her alive on 4th Oct 1947
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
Due to _____
Due to _____

Other conditions arteriosclerosis 2 yrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration 6 days
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)
(c) Means of injury _____

23. Signature Dr. Theo. Berger (M. D. or other) MD
Address 4500 Olive St Date signed 11/27/47

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

Alv. Greiner
4500 Olive
Lister Bldg
Lo. 3800

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, ~~Alv. Greiner~~

~~Residence Address No.~~

~~Signature~~

Robert L. Brinkman
Licensed Embalmer No. 3553
P. O. Address 2849 N. Euclid

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.