No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 6 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2130

Registration District No. 310 — Primary Registration District No. 3058 — Registrar's No. 24

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Josephs Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10. Da. (Specify whether
In this community 10 Da years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Overland (If outside city or town limits, write "RURAL")
(d) Street No. 3579 St. Christopher (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sally Ann Bruce
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan. 12, 1948 (Month) (Day) (Year)

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace St. Charles (City, town, or county) Mo. (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER
12. Name David Bruce
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Dorthey Hahn
15. Birthplace Lutesville (City, town, or county) Mo. (State or foreign country)
16. (a) Informant David Bruce
(b) Address 3579 St. Christopher
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1)23)48 (Month) (Day) (Year)
(c) Place: burial or cremation Wellsville Cemetery
18. (a) Signature of funeral director Colliers Funeral Home
(b) Address 10123 St. Charles Rd.
19. (a) 1-31-48 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1948 hour 8 PM minute M.
21. I hereby certify that I attended the deceased from Jan 12 1948, 19, to Jan 21, 1948 that I last saw her alive on 1-21-48, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congenital defect multiple	9 days
Due to: Hydrocephalus, Spina Bifida, Hygroma of Neck	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy as above

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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
Signature Paul B Vallerotti (M. D. or other) MD
Address 10300 St Charles Rd Date signed 1/22/48
(14) St Louis Co

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 0
District File Number
Date Filed 2/5/48

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 No Embalming

Licensed Embalmer No. .....

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.