

No. 300  
-10-47  
-5-17-39  
PI 3906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33883**

FILED OCT 13 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8659**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
4133 Turner  
(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 one

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. 4133 Turner 9  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel Babe

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3rd.  
year 1948 hour 1:00 minute \_\_\_\_\_ P.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Roy F. Babe

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Jan. 4th. 1906  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 8.  
1947, to Oct 3rd. 1948  
that I last saw her alive on Oct 3rd. 1948  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>8</u>	<u>29</u>	hr. _____ min. _____

Immediate cause of death \_\_\_\_\_

Periculous Anemia 2 to 3  
years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace St. Louis, Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Nicholas Heilweck

13. Birthplace St. Louis, Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Mae McKernan

15. Birthplace St. Louis, Mo. 0  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Roy F. Babe

(b) Address 4133 Turner

17. (a) Burial (b) Date thereof 10/7/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Sullivan Funeral Dir.

(b) Address 2849 North Euclid Ave.

19. (a) \_\_\_\_\_  
(Date received local registrar)

(b) \_\_\_\_\_  
(Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) \_\_\_\_\_ of injury \_\_\_\_\_

23. Signature Dr. Paul H. Chapman M.D.

Address 357 E. 12th St. Date signed 10/7/48

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

MOTHER FATHER

Dr. Paul Chapman

3518 Dodier St.

NE. 1260

---

---

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 *Robert L. Brindeman*

Licensed Embalmer No. *3553*

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.