FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 8 1949

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42931

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. [illegible]

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Pine Crest Home 4
(If not in hospital or institution, write street, number or location)

(d) Length of stay: In hospital or institution 14 days (Specify whether
In this community Yes
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 96 0 0

(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 1

3. (a) PRINT FULL NAME Ann Butler

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

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

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife .....

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

7. Birth date of deceased Don't know
(Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business Mo

FATHER
12. Name N 9
13. Birthplace .....
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Pine Crest Homes
(b) Address Ballwin Mo.

17. (a) Anatomical Board (b) Date thereof 2-4-49
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of [illegible] Rowland Mortuary Service
(b) Address 4104 Manchester Ave.

19. (a) 12-31-49 (b) [illegible]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 31
year 1948 hour 8 minute P.M.

21. I hereby certify that I attended the deceased from Dec 22 1948, to Dec 31 1948; that I last saw her alive on Dec 27 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis	
Due to 93d	
Due to	
Other conditions (Include pregnancy within 3 months of death) 7	
Major findings: Of operations 42	
Of autopsy	

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 0

23. Signature A. T. Merkling MD (M. D. or other) MD

Address 3507 Potomac Date signed 1-18-49

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. [redacted]

K43880

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

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
Pine Crest Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days (Specify whether years, months or days)

In this community _____

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 _____

3. (a) PRINT FULL NAME Ann Butler

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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased dont know (Month) (Day) (Year)

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

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

10. Usual occupation _____

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 Pine Crest Homes

(b) Address Ballwin Mo

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Howland Mortuary

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ 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)	

Major findings:
Of operations _____

Of autopsy _____

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? _____ (Specify type of place)

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-42931