

FILED FEB 7 1946

STANDARD CERTIFICATE OF DEATH

State File No. **334**
Registrar's No. **885**

Registration District No. **318** Primary Registration District No. **1003**

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:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 weeks
(Specify whether years, months or days)

In this community 30 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5317 Devonshire
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary F. Godin

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month January day 25 year 1946 hour 2 minute 20 P. M.

4. Sex female 5. Color or race White

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

6. (b) Name of husband or wife Robert E. 6. (c) Age of husband or wife if alive 1946-1899 years

7. Birth date of deceased: Feb. 15
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 3 1944 to Jan 25 1946; that I last saw her alive on Jan 25 1946; and that death occurred on the date and hour stated above.

8. **AGE:** Years Months Days If less than one day

46	11	10	hr. min.
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9. Birthplace Mt. Olive Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Immediate cause of death: Carcinoma of liver Duration Six mos.

Due to Carcinoma of breast 6/7/1944 2 yrs.

11. Industry or business _____

12. Name George Calvin

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

14. Maiden name Anna Zvonar

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

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Ca of breast

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Robt. E. Godin

(b) Address 5317 Devonshire

17. (a) Burial (b) Date thereof 1-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive, Ill
J.L. Ziegenhein & Sons

18. (a) Signature of funeral director _____

(b) Address 7027 Gavois Ave.

19. (a) JAN 28 1946 (b) J. F. Brudbeck
(Date local registrar) (Registrar's signature)

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 Holaid S. Wepfer (M. D. or other) _____
Address 4500 Olive Date signed 1/26/46

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

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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. *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address. *Overland Park Mo*

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.