N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC 6 NOV 16 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

34304
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 9290
(c) City St. Louis (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 10867

2. PRINT FULL NAME 425 Elizabeth Nelson
(a) Residence, No. 2603 Hickory St. 22
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 16 1895
7. AGE: 43 YEARS, MONTHS: 7, DAYS: 9 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. hwk
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 1

FATHER
13. NAME John Rice
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 1

MOTHER
15. MAIDEN NAME ?
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ? 9

17. INFORMANT (ADDRESS) Hosp. Info M. Kent
18. BURIAL, CREMATION, OR REMOVAL PLACE SUNSET BURIAL Park DATE Oct. 27 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. Schnur 3125 Lafayette av.
20. FILED OCT 26 1938 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/25/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 10/23/38, 19, to 10/25/38, 19
I last saw her alive on 10/25/38, 19 Death is said to have occurred on the date stated above, at 1. a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Subarachnoid hemorrhage	10/23/38

Other contributory causes of importance:
Essential Hypertention
Arterio Sclerosis

Name of operation none Date of 10/24/38
What test confirmed diagnosis? Spinal Puncture Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: no.
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Edward J. Weiss, M. D.
(Address) City Hospital No. 1

(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, Jos B Vollmer, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave.

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

If this body is not embalmed, above space should be left blank.