

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.

REC'D AUG 17 1939

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

6184

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:
3953 A EASTON W
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2953 A EASTON
(Specify whether)
 In this community 80 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
 (d) Street No. 3953 A EASTON
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
 year 1939 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from July - 11 - 1939 to July - 11 - 1939
 that I last saw her alive on July - 11 - 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Cystitis
non Catarrhal
non Gonorrhoeal
non tubercular
 Duration one year

Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy no

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? _____

3. (a) PRINT FULL NAME NANCY JANE SMITH 530
 3. (b) If veteran, name war _____ 3. (c) Social Security No. NINE

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife MATHEW 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased MAR 14 1845
(Month) (Day) (Year)

8. AGE: Years 94 Months 3 Days 28
 If less than one day _____ hr. _____ min.

9. Birthplace RED BUD ILL
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK
 11. Industry or business AT HOME

MOTHER FATHER
 12. Name ROBERT NELSON
 13. Birthplace RED BUD ILL
(City, town, or county) (State or foreign country)
 14. Maiden name Mrs. McWEN
 15. Birthplace RED BUD ILL
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Augusta Lee
 (b) Address 3953 A Easton

17. (a) Burial (b) Date thereof JULY 14 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ZION
 18. (a) Signature of funeral director Cullen Kelly
 (b) Address 1414 N. Taylor

19. (a) 11 13 1939 (b) J. F. Braddock
(Date received local registrar) (Signature of registrar)

While at work? _____ (Specify type of place)
 (a) Means of injury 1
 22. Signature James M. Haven (M. D. or other)
 Address 2026 S. Jefferson Date signed _____

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.....

Clement McNeary

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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, above space should be left blank.