

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 9 1939
Registration District No. **780**

Primary Registration District No. **115**

Registrar's No. **2100**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Christian Old Peoples' Home **3**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 years
(Specify whether
 In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Mrs. Lydia Temple **514**
8. (b) If veteran, name war _____ **8. (c) Social Security** No. _____

4. Sex Female **5. Color or race** White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife WILLIAM TEMPLE **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased February 2 1850
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business RETIRED

12. Name UNKNOWN

18. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

14. Maiden name BARKER

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

16. (a) Informant's own signature R. J. TEMPLE

(b) Address 6530 BARTMER

17. (a) BURIAL **(b) Date thereof** 12-1-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAUREL HILL

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address W. E. Hamilton Ave

19. (a) NOV 29 1939 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State 1 (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 29th
 year 1939 hour 5 minute _____ M.

21. I hereby certify that I attended the deceased from Dec 1939 25th, 1939, to Nov 29, 1939;
 that I last saw her alive on Nov 28th, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
& uremia
 Duration _____ days

Due to Cerebral arteriosclerosis
& hypertension moderate
 Due to _____

Other conditions 8701
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
 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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Thrays (M. D. or other) M.D.
 Address 6600 Washington Date signed 11-29-39

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 *Albert S. Hoppa*

Licensed Embalmer No. *2971*

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, above space should be left blank.