

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **10378**

1. PLACE OF DEATH: **1000**
 (a) County _____
 (b) City or town **St. Louis**
 (c) Name of hospital or institution:
4012 a Palm St
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME **Margaret Stine** **350**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Orrin Stine** 6. (c) Age of husband or wife if alive **57** years
 7. Birth date of deceased **July 20 1885**
 (Month) (Day) (Year)

8. AGE: Years **54** Months **4** Days **12** If less than one day
 hr. _____ min. _____

9. Birthplace **St. Louis Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____
 MOTHER FATHER { 12. Name **John J Finan**
 13. Birthplace **Ireland**
 14. Maiden name **Mary Monahan**
 15. Birthplace **Ireland**

16. (a) Informant's own signature _____
 (b) Address **4012 a Palm St**

17. (a) **Burial** (b) Date thereof **12/6/39**
 (c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Stroot - Carroll**
 (b) Address **4600 Natural Bridge Ave**

19. (a) **DEC 4 1939** (b) **J. F. Braduch**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **1**
 (c) City or town **St Louis**
 (d) Street No. **4012 a Palm St**
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **2**
 year **1939** hour **6** minute **30 p** M.

21. I hereby certify that I attended the deceased from **Dec 17 39**
Dec 7, 19**39**, to **Dec 2**, 19**39**
 that I last saw her alive on **Dec 2**, 19**39**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma Cervix uteri**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____
 (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 **Hans Recklerhoff** (M. D. or other) _____
 Address **2739 71 Grand** Date signed **12/14/39**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE PRINT IN UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1 X1931

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

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.