

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County 2
(b) City or town St. Louis
(c) Name of hospital or institution: 926 A Morrison Ave.
(d) Length of stay: In hospital or institution None
In this community 26 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis
(d) Street No. 926 A Morrison
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Sarah Jane Ripley 140
(b) If veteran, name war None (c) Social Security No. None
4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 17, 1855

8. AGE: Years Months Days If less than one day
84 1 6 hr. _____ min.

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

10. Usual occupation Housework
11. Industry or business At Home

12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mable Clark
(b) Address 1212 Hickory

17. (a) Removal (b) Date thereof 12/27/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Graville, Illinois

18. (a) Signature of funeral director St. M. Laughlin
(b) Address 2301 Lafayette Ave.

19. (a) DEC 26 1939 (b) J. P. Brundage
(Date of death) (Embalmer's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 23
year 1939 hour 5 minute 25 P. M.
21. I hereby certify that I attended the deceased from July
6 1939 to Dec 23 1939

that I last saw her alive on Dec 23 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to Arterial Sclerosis

Due to MI

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? (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
28. Signature G. M. Paul (M. D. or other) MD
Address 1755 So. Lindbergh Date signed 12-26-39

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

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.

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 L. R. Cooper

Licensed Embalmer No. ~~363~~ 365

P. O. Address 2317 Lafayette

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.