

Registration District No. **791**

Primary Registration District No. **1003**

FILED FEB 17 1940

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:
4521 Nebraska
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Minnie Tallent**
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 **Divorced**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **January 1 1915**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	25	0	26	hr. _____ min.

9. Birthplace _____ **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Heel coverer**

11. Industry or business _____

12. Name **Aaron Tallent**

18. Birthplace _____ **Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Pearl Reeves**

15. Birthplace _____ **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Julia Allman**

(b) Address **1540 S. Seventh**

17. (a) **Burial** (b) Date thereof **1-30-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cem.**

18. (a) Signature of funeral director **Schumacher Und. Co.**

(b) Address **3013 Meramec**

19. (a) **JAN 30 1940** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** **15**
(If outside city or town limits, write "RURAL")
(d) Street No. **4521 Nebraska (rear)**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years
No Physician in Attendance

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **27**
year **1940** hour **2:25** minute **0** P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Illuminating Gas Poison; self administered at her home 4521 Nebraska**
Due to **Poison Jan 27th 1940 at about 2:25 P.M.**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings _____
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
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) **suicide**
(b) Date of occurrence **Jan. 27 1940**
(c) Where did injury occur? **St. Louis Mo**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home
While at work? **No** (Specify type of place) (e) Means of injury **LL**

28. Signature **Joseph M. Allman** (Att. or other)
Address **Deputy** Date signed _____

USE 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.

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.....

George J. Chaulaud
working under my personal supervision.

Registered Apprentice No.

George J. Chaulaud
Signed.....

Licensed Embalmer No. *2906*

P. O. Address. *3023D Perimeter*

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.