

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis Missouri
(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of Hospital or Institution: Desloge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: one week
In this community 70 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Saunders, Mrs. Julia

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Joseph Saunders 6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased May 2 1869
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 16 If less than one day hr. min.

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

10. Usual occupation Seamstress

11. Industry or business Dress Factory

12. Name Patricia O'Neal

13. Birthplace Delaware (City, town, or county) (State or foreign country)

14. Maiden name Paula Kennedy

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

16. (a) Informant Mr. Row

(b) Address 5229 Waterman

17. (a) Burial (b) Date thereof Feb 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 4212 St. Louis Ave

19. (a) **FEB 19 1940** (b) [Signature]
(Date received local registrar) (City, town, or county)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
(d) Street No. 5833 Pine
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17
year 1940 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 13
1940, to Feb 17 1940

that I last saw her alive on Feb 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Staphylococcus septic pneumonia - small left empyema

Due to Staphylococcus Septicemia

Due to Carbuncle of upper lip & cellulitis of face

Other conditions senility hypertension basal cell carcinoma of forehead

Major findings: As of physical exam

Of autopsy As of physical exam + Septic pneumonia - Staphylococcus

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 [Signature] (M.D. or other) MD

Address Firmin Desloge Hospital Date signed 2/18/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

jos. A. Howards

Licensed Embalmer No. *4139*

P. O. Address *4212 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.