

MAY 15 1940

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3752

1. PLACE OF DEATH:

(a) County _____
 (b) City or town Saint Louis, Missouri.
 (c) Name of hospital or institution: St. Anthony Hospital.
 (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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County _____
 (c) City or town Saint Louis, 15
 (If outside city or town limits, write "RURAL")
4342 Miami Street.
 (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 April day 23rd.
 year 1940. hour 11 minute 50 A. M.

21. I hereby certify that I attended the deceased from April 7, 1940, to April 23, 1940, that I last saw her alive on April 23, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Embolism half hour
 Due to: Hysterectomy 1 1/2 16 days
 Due to: _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Uterian Fibroids small
non-malignant
 Of autopsy: No

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

23. Signature Albert B. Bina (M. D. or other) _____
 Address 1941 1124 Date signed 4/25/40

3. (a) PRINT FULL NAME Ann G. Calvert 416
 8. (b) If veteran, name war _____ 8. (c) Social Security No. 489-10-8512

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 11th, 1896.
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 0 12 _____ hr. _____ min.

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

10. Usual occupation File Clerk

11. Industry or business _____

12. Name George Calvert 1

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

14. Maiden name Mary Doll

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

16. (a) Informant's own signature George Calvert
 (b) Address 4342 Miami Street.

17. (a) Burial (b) Date thereof April 26, 40.
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Ziegenhain's Bros.
 (b) Address 2624 Cherokee Street.

19. (a) APP 25 1940 (b) J. T. Brubaker
 (Date received for registration) (Registrar's signature)

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 *V E Morris*

Licensed Embalmer No. *3360*

P. O. Address *2623 Cherokee*

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.