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-10-39
-7-39
X21492

REC-79 117 1940

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 5047

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(c) Name of hospital or institution _____
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

8. (a) PRINT FULL NAME Eva G. Meil

8. (b) If veteran, name war MO 8. (c) Social Security No. _____

4. Sex Female 5. Color of hair Wh 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 May 23 1873
(Month) (Day) (Year)

8. AGE: Years 63 Months 14 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation school teacher

11. Industry or business Public Schools

12. Name Eva G. Meil

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

14. Maiden name Elizabeth Brown

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

16. (a) Informant Mrs Robert Dunn

(b) Address 5236 Maple Ave

17. (a) burial (b) Date thereof 6-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director James Stewart
(b) Address 1225 Union St

19. (a) JUN 10 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 5
(c) City or town St Louis
(d) Street No. 5236 Maple
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, month June day 7 10:07 A.M.
year 1940 hour _____ minute _____

21. I hereby certify that I attended the deceased from 6-3-40
6- 1940, to 6-7 1940;
that I last saw her alive on 6-6 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis, Pneumococci # 15 Duration 4 days

Due to _____

Due to _____
Other conditions Hypertension
(Include pregnancy within 6 months of death)

Major findings: _____
Of operations _____

Operative _____

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) _____
Means of injury _____

23. Signature J. P. Quady (M. D. or other) MD
Address 1007 N. Bond Date signed 6-10-40

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

5047
5047

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

Bernard A. J. Stuart

Licensed Embalmer No.

3500

P. O. Address

1225 Union, Pa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.