

Registration District No. **791** Primary Registration District No. **17**

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:
4247 Castleman Ave.
(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 **Mo.** (b) County _____
(c) City or town **St. Louis.** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4247 Castleman Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28th.**
year **1940** hour **4.** minute **00** A.M.

21. I hereby certify that I attended the deceased from **June 3**, 19**40**, to **June 28**, 19**40**.
That I last saw him alive on **June 26**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy** Duration **26 days**
Due to **Myocardium and Coronary Arteriosclerosis**
Due to _____

Other conditions noted (include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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?

23. Signature **A. Louis Schuchat** (M., D., or other) _____
Address **2200 Chabau av** Date signed **6-28-40**
While at work? _____ (Specify type of place) (e) Means of injury _____

3. (a) PRINT FULL NAME **MARY A. OWENS.** **520**
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 **Single.**

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

7. Birth date of deceased **July 16, 1854**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 11 12 hr. _____ min.

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

10. Usual occupation **At Home.** **RETIRED**

11. Industry or business _____

12. Name **John Owens.**

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

14. Maiden name **Mary A. Fox.** (State or foreign country)

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

16. (a) Informant **Miss Ann-Creamer.**

(b) Address **4247 Castleman Ave.**

17. (a) **Burial.** (b) Date thereof **7-1-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd.**

19. (a) **JUN 28 1940** (b) **J. F. Burtch**
(Date received local registrar) (Registrar's signature)

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

*Mr. Johnson
2300 Charleston Ave
12-6 Pa*

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 W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address _____

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.