

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.

Registration District No. 784

Primary Registration District No. 113

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town University City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Christian Old Peoples' Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
University City.  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 6600 Washington Ave.,  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mrs. Anna G. Blewett 430  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 29th.  
1940 year hour 7 minute 25 P. M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 8th. 1859  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug, 1940, to Aug 29, 1940;  
 that I last saw her alive on Aug 27, 1940;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>1</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death  
Chronic Detrital Pyelitis 7 yr  
 Duration

9. Birthplace Oakland, Ky.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Retired

Due to \_\_\_\_\_  
 Due to 131  
 Other conditions 131  
(Include pregnancy within 3 months of death)

11. Industry or business Thompson Gossom  
 MOTHER FATHER { 12. Name \_\_\_\_\_  
 13. Birthplace Rich Hill, Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Lucinda Perkins Newman  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Mary C. Gray  
 (b) Address 6600 Washington Ave.  
 17. (a) Burial (b) Date thereof 8-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Smith Grove Ky.  
 18. (a) Signature of funeral director Shepard Funeral Home  
 (b) Address 1167 Hamilton Ave.  
 19. (a) AUG 30 1940 R.R. Miller  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury \_\_\_\_\_  
 While at work? \_\_\_\_\_  
 23. Signature J. P. Ryan (M. D. or other) \_\_\_\_\_  
 Address 607 N. Grand St. Date signed 2-30-40

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**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..... *Gay W Wilkinon*

Licensed Embalmer No..... *3575*

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.**