

No. 2  
-11-10-39  
5-17-39  
-1 X21492

State File No. \_\_\_\_\_

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

FILED DEC 11 1940

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of town)  
(c) Name of hospital or institution:  
City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Remained dead  
(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  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6318 Vermont  
(If rural, give location)  
(e) ~~Physician~~ \_\_\_\_\_ years

3. (a) PRINT FULL NAME Marie E. Durant

3. (b) If veteran, name war Navy 3. (c) Social Security No. 424-03-5411

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Oct 3 1891  
(Month) (Day) (Year)

8. AGE: Years 49 Months 1 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Candy Maker 0

11. Industry or business Candy 0

12. Name Mansfield Durant 0

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

14. Maiden name Nellie Kaven

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

16. (a) Informant Nellie Durant

(b) Address 6318 Vermont

17. (a) Burial (b) Date thereof Nov 4 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope

18. (a) Signature of funeral director Southern

(b) Address 6322 Grand Blvd

19. (a) NOV 4 1940 (b) J. P. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2  
year 1940 hour 9 minute 15 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Cerebral Apoplexy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 Frederic L. Berryman  
Licensed Embalmer No. 4018  
P. O. Address St. Louis Mo.

**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.**