

FILED APR 13 1942

Registration District No.

Primary Registration District No.

1003

Registrar's No.

2894

1. PLACE OF DEATH: **791**

(a) County.....

(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4474 ARCO
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **1**
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County..... **183000**

(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL") **179**

(d) Street No. **4474 ARCO**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Laura Josephine Brown**

3. (b) If veteran, name war.....

3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **Mar. 18 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

72 0 11 .hr. .min.

9. Birthplace **Sullivan, Mo.** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **House Wife**

11. Industry or business.....

MOTHER FATHER { 12. Name **Charles Cunio**

13. Birthplace **Italy** (City, town, or county) (State or foreign country) **5**

14. Maiden name **Unknown**

15. Birthplace **II II II** (City, town, or county) (State or foreign country) **9**

16. (a) Informant **Gertrude Beckemeyer**

(b) Address **4474 Arco**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **3/31/42**
(Month) (Day) (Year)

(c) Place: burial or cremation **Rosebud Mo**

18. (a) Signature of funeral director **Albert H Hoppe**

(b) Address **4700 Washington**

19. (a) **AP 31 1942** (Date received local registration) **J. F. Gledes** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **29**
year **1942** hour..... minute..... M.

21. I hereby certify that I attended the deceased from **March 2**
19 **42** to **March 29**, 19 **42**
that I last saw her alive on **March 2**, 19 **42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Sclerotic Heart Disease**

Due to **Cardiac Decompensation**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration

10 yrs.

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?.....

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

23. Signature **H. R. Bremser** (M. D. or other)
Address **4266 MANCHESTER** Date signed.....

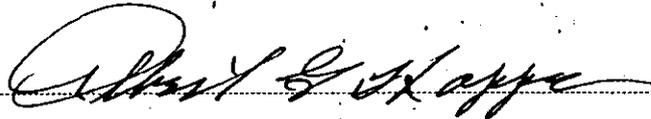
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

791

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.....



Licensed Embalmer No.....

2971

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, fact should be so stated above.