

FILED OCT 14 1942 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

8219

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:
2029 Alice 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)

3. (a) PRINT FULL NAME **Emma W. Mellies**

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 **Widowed**
6. (b) Name of husband or wife **Henry L. Mellies**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Jan. 14 1861**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 8 19 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

MOTHER FATHER

12. Name..... **Francis Brinkman**
13. Birthplace..... **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name..... **Charlotte Gahner**
15. Birthplace..... **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Amanda Mellies**

(b) Address **2029 Alice Ave.**

17. (a) **Burial** (b) Date thereof **10-5-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Johns Cem.**

18. (a) Signature of funeral director **Drehmann-Harral**

(b) Address **1905 Union Blvd.**

19. (a) **OCT 5 1942** (b) **J. F. Prudack**
(Date received local registrar) (Registrar's signature)

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. **2029 Alice Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **3**
year **1942** hour **4** minute **05** A.M.

21. I hereby certify that I attended the deceased from **6-1-42** 19 to **Oct 3** 19 **42**
that I last saw **her** alive on **Oct 2** 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.

**Acute Cardiac Dilatation
Cerebral Embolism**

Due to..... **Chr. Bronchitis**

Due to.....

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

Major findings:

Of operations.....

Of autopsy.....

Duration

3 day

3 m.

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 **E. A. Mellies** (M. D. or other).....

Address **2732 N. Grand** Date signed **10-5-42**

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

12-2 PM
Kiddell Street

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..... *Albert R. Thompson Jr.*
Licensed Embalmer No..... *4237*
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.