

FILED OCT 21 1942
318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 mos., 12 days**
In this community **31 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Clara Drasdell**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Cal** 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 **Dec 17 - 1880**
(Month) (Day) (Year)

8. AGE: Years **62 61** Months **9** Days **21** If less than one day _____ hr. _____ min.

9. Birthplace **Pallasca County, Ill**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business _____

12. Name **Not known**
13. Birthplace **Not known** 9
(City, town, or county) (State or foreign country)

14. Maiden name **Emma** **not known** 9
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Faustina Snodden**
(b) Address **2718 N 2nd Street, St. Louis**

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

(c) Place: burial or cremation **Mount City, Ill**

18. (a) Signature of funeral director **A.P. Richardson**
(b) Address **2625 Glasgow**

19. (a) **OCT 10 1942** (b) **J.F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis,** **9 21**
(If outside city or town limits, write "RURAL")
(d) Street No. **1011a 21st St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **8,**
year **1942** hour _____ 2 minute **25 P.** M.

21. I hereby certify that I attended the deceased from **July 26,** 19**42** to **October 8,** 19**42;**
that I last saw her alive on **October 8,** 19**42;**
and that death occurred on the date and hour stated above.

Immediate cause of death:
Hypertensive Heart Disease with Cardiac Decompensation

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)
(c) Means of injury _____

23. Signature **S.E. Smith** (M. D. or other)
Address **2601 Wheeler** Date signed **10/10/42**

Duration
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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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 *W. Richardson*
Licensed Embalmer No. *2928*
P. O. Address *2625 Glasgow*

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.