

FILED FEB 1 1943 318

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town.....
 (c) Name of hospital or institution.....
 (d) Length of stay: In hospital or institution.....
 In this community..... years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town.....
 (d) Street No.....
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME.....

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... AM.

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

21. I hereby certify that I attended the deceased from..... to..... that I last saw her alive on..... and that death occurred on the date and hour stated above.

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

Immediate cause of death.....

7. Birth date of deceased..... (Month) (Day) (Year)

Due to.....

8. AGE:	Years	Months	Days	If less than one day
	64	0	1	hr. min.

Due to.....

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

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

10. Usual occupation.....

Major findings: Of operations.....

11. Industry or business.....

Of autopsy.....

12. Name.....

22. If death was due to external causes, fill in the following:

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

(a) Accident, suicide, or homicide (specify).....

14. Maiden name.....

(b) Date of occurrence.....

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

(c) Where did injury occur?..... (City or town) (County) (State)

16. (a) Informant..... (b) Address.....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

17. (a) (b) Date thereof..... (Month) (Day) (Year)

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

(c) Place: burial or cremation.....

23. Signature..... (M.D. or other) Address..... Date signed.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) Date received by Registrar..... (b) Registrar's signature.....

Duration

3 days

Unknown

Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Frank J. Hand*.....

Licensed Embalmer No..... *2645*.....

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, fact should be so stated above.