

APR 19 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2842

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Isolation Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hrs
(Specify whether
In this community 15 yrs
years, months or days)

3. (a) PRINT FULL NAME Elsie Colin

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Francis Colin 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Aug 25 1901
(Month) (Day) (Year)

8. AGE: Years 41 Months 6 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Andrew Hoffmann

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

14. Maiden name Julie Sutter

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

16. (a) Informant Francis Colin

(b) Address Overland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/43
(Month) (Day) (Year)

(c) Place: burial or cremation Parryville Mo

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Overland Mo

19. (a) MAR 25 1943 (Date received local registrar) (b) J. J. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 8541 St Charles Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 24
year 1943 hour _____ minute 12:45 AM

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 _____

Diphtheria

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 Alfred Perry (M.D. or other) _____

Address St. Charles Date signed 3/24/43

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

MOTHER FATHER

NR

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JAN 2 01944

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

J. C. Ostmann

Licensed Embalmer No. *3478*

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.