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V. S. No. 2
100M-2-43
Rev. 5-17-39
X93697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30255**
Registrar's No. **8507**

FILED OCT 2 - 1943 318

Registration District No. _____ Primary Registration District 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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 Days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Lily Nute
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 WIDOW
6. (b) Name of husband or wife J. L. NUTE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased SEPT 21 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 0 4 _____ hr. _____ min.

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

10. Usual occupation NONP

11. Industry or business _____

MOTHER FATHER { 12. Name SAMUEL JONES
13. Birthplace IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH BURDETT
15. Birthplace FRANCE
(City, town, or county) (State or foreign country)

16. (a) Informant SISTER JEANE
(b) Address 3225 N. FLORISSANT AVE.

17. (a) BURIAL (b) Date thereof 9-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation GALATRY CEMETERY

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 2840 Lindell Blvd

19. (a) SEP 27 1943 (b) J. F. Burdick
(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. 3225 N. FLORISSANT AVE.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 24,
year 1943 hour 4:15 minute P. M.
21. I hereby certify that I attended the deceased from August 26, 1943 to September 24, 1943

that I last saw him or alive on September 24, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of anus Duration _____

Due to _____
Due to _____

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

Major findings: Arteriosclerosis PHYSICIAN _____
Of operations _____
Of autopsy Confirm above
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 Robert R. Hartman (M. D. number) _____
Address 1515 Lafayette Avenue Date signed 9/25/43

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.