

FILED NOV 27 1943
Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Manchester**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Manchester Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community. (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Wellston**
(If outside city or town limits, write "RURAL")
(d) Street No. **6755 Roberts Ave.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Elizabeth Mikels.**

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

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

6. (b) Name of husband or wife **Herman F. Mikels** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec. 24, 1875.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 10 24 hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER { 12. Name **Unknown**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Geo. Wolff**

(b) Address **6018 Etzel Ave.**

17. (a) **Burial** (b) Date thereof **Nov. 22/43.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiamont Ave.**

19. (a) **NOV 22 1943** (b) **E. G. McCarroll, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **18**
year **1943** hour **6.00** minute **F.M.** M.

21. I hereby certify that I attended the deceased from **1-1-41**
_____ 19____ to **11-18** 19**43**
that I last saw her alive on **11-17** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chr. Myocarditis**

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 **Dr. Denny** (M. D. or other) **MD**
Address **Creve Coeur, Mo.** Date signed **10-19-43**

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

96
00

JAN 15 1948

MAR 1 1948

*Chas. H. Seaman
Tommy Stone 4-23618
T.E.*

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.....

Licensed Embalmer No. *1661*

P. O. Address *112 57 Hodiannuit*

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.