

FILED FEB 27 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: **318**  
(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:  
4929 Pernod Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED: **0017**  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4929 Pernod Ave. (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nellie Adams  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 17  
year 1944 hour 1 minute 30 P.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow  
6. (b) Name of husband or wife Capt. James W. Adams 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Sept. 6 1856  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 14, 1943, to Jan 17, 1944  
that I last saw her alive on Jan 16, 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
87 4 11 hr. \_\_\_\_\_ min.

Immediate cause of death: Acute Cardiac Decompensation 5 days  
Due to Chronic Myocarditis 9 yrs.

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

Due to \_\_\_\_\_  
Other conditions: Hypertension 9 yrs.  
(Includes pregnancy within 3 months of death)

10. Usual occupation Home

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

11. Industry or business \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

12. Name Snelling

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

14. Maiden name Sarah E. Spooner

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

16. (a) Informant Mrs. Ida Learns

(b) Address 4929 Pernod

17. (a) Burial (b) Date thereof Jan. 20, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Walter Hilderich M.D.

(b) Address 3654 Gravois Ave.

19. (a) JAN 20 1944 (b) J. F. O'Rourke  
(Date received local registrar) (Registrar's signature)

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

(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) (2) Means of injury \_\_\_\_\_

23. Signature J. F. O'Rourke (M. D. or other) Med  
Address 5920 Southwest Ave. Date signed 1-19-44

24. (a) JAN 20 1944 (b) J. F. O'Rourke  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

SVV

**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. Dylanes*

Licensed Embalmer No. ....

*26457*

P. O. Address.....

*A. Louder*

**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.**