

FILED SEP 8 1944 18

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 7588

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3150 Pennsylvania /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 14 years St. Louis (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 024

(d) Street No. 3150 Pennsylvania
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Goldie Warren-Dunn

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31
year 1944 hour 12 minute 05 P.M.

21. I hereby certify that I attended the deceased from August 27th, 1944, to Aug 30, 1944
that I last saw h. GR alive on Aug 30, 1944, to _____
and that death occurred on the date and hour stated above.

4. Sex Female / Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clarence B. Dunn

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

7. Birth date of deceased May 30, 1900
(Month) (Day) (Year)

Immediate cause of death _____
Carcinoma, Primary in uterus with hepatic metastasis

Due to _____

Due to _____

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

8. AGE: Years Months Days If less than one day

44 3 1 hr. _____ min. _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Abner Chasteen

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

14. Maiden name Sarah Ray

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

16. (a) Informant Maxine Davisson

(b) Address 3150 Pennsylvania

17. (a) Burial removed (b) Date thereof 9-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Presbyterian Cem Salem, Mo

18. (a) Signature of funeral director Thomas Kates & Son

(b) Address 2906 Gravois Ave

19. (a) SEP 1 1944 (b) J. J. Bradeau
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place) _____

(e) Means of injury _____

23. Signature Herbert Kadi (M. D. or other) M.D.

Address 6532 Gravois Ave Date signed 9/1/44

844 (Licensed Embalmer's Statement on Reverse Side)

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

Dr. Pauli
352

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..... *David Van Fossan*.....

Licensed Embalmer No. *4242*.....

P. O. Address..... *2906 Grannis*.....

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.