

FILED JAN 25 1945

397

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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

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: Pronounced dead at City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 (Specify whether
In this community 3 years, months or days)

3. (a) PRINT FULL NAME ALBERTA RAYMOND
(b) If veteran, name war
(c) Social Security No.

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced, SINGLE
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased U. K. (Month) (Day) (Year)

8. AGE: Years ABOUT 65 Months Days If less than one day hr. min.

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

10. Usual occupation HOUSE WORK

11. Industry or business AT HOME

12. Name Geo M RAYMOND

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

14. Maiden name MARY M. CASEY

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

16. (a) Informant Leo Soboson

(b) Address Ridgewood 30 PANCA

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 15 1945 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director C. Kelly

(b) Address 4386 Lindell

19. (a) JAN 15 1945 (Date received local registrar) (b) J. F. Bredek (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. 925 CATALPA (If rural, give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 13 year 1945 hour 9 minute P. M.

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 Coronary Occlusion
arteriosclerosis

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 John E. Doyle (M. D. or other) _____

Address _____ Date signed 1/13/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 James A. Lammer
Licensed Embalmer No. 4142
P. O. Address St. Louis

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.