. S. No. 2
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I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21635

FILED AUG 31 1945

Registration District No. ____ Primary Registration District No. 1003

State File No. ____ Registrar's No. 6577

1. PLACE OF DEATH:

(a) County ____
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2609 S. Grand Blvd. Memorial Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 years (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
(c) City or town Saint Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2609 S. Grand Blvd.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Nellie Mae Austin
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 Married
6. (b) Name of husband or wife Archibal J. Austin
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased May 19, 1869 (Month) (Day) (Year)

8. AGE: Years 76 | Months 2 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation At home
11. Industry or business ____
FATHER
12. Name Thomas Little
13. Birthplace ____ (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Malissa Foster
15. Birthplace ____ (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. James Little,
(b) Address 2613 Park Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery
18. (a) Signature of funeral director Craig Mortuary
(b) Address 4468 Washington
19. (a) JUL 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26th year 1945 hour 3-45 minute P. M.
21. I hereby certify that I attended the deceased from 1942 ____, 19__ to ____, 19__; that I last saw her alive on July 26th, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Uraemia	48 hrs
Due to Chr. Int. Nephr	2 yrs
Due to Arteriosclerosis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy	

PHYSICIAN — 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature [illegible] (M. D. or other) M.D.
Address 3103 Arsenal St. Date signed 7/27/45

(Licensed Embalmer's Statement on Reverse Side)

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. 3281

P. O. Address 4468 Washington Blvd.

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.