

FILED *SEP 21 1946*

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8759**

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:
Bethesda Hospital
(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:
(a) State **Missouri** (b) County _____
(c) City or town **4527 Forest Park Blv'd.,**
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Louis,**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SARAH E. YANTIS.**
(b) If veteran, name war **none**
(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 **Rochester Yantis.**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 10, 1861.**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **OCT.** day **11**
year **1946** hour **6** minute **10-R** M.
21. I hereby certify that I attended the deceased from **March**
24 to **Oct 11**, 19 **46**
that I last saw h. **aw** alive on **Oct 10**, 19 **46**
and that death occurred on the date and hour stated above.

8. AGE: — Years Months Days If less than one day
85. **7.** **1.** hr. min.

Immediate cause of death
Cerebral Hemorrhage Duration **21 days**
Due to **Arteriosclerosis** **Senility** **9/11** **10 yrs**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace **Macon, Missouri.**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home.**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name **John Howe.**
13. Birthplace **Kentucky.**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown.**
15. Birthplace **Kentucky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs A. F. Kerckhoff.**
(b) Address **6254 Wydown Blv'd.,**

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?

17. (a) **Removal.** (b) Date thereof **10/12/46.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Salem, Oregon.**

(Specify type of place) _____
(e) Means of injury _____
23. Signature **May Stahlhoff** (M. D. or other) **MD.**
Address **512 Dow Ave** Date signed **10/14/46**

18. (a) Signature of funeral director **C.R. Lupton & Sons.**
(b) Address **7233 Delmar Blvd.**
19. (a) **OCT 11 1946** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

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

Dr. Murray
#512 Dover Pa.
LO-1706
12-3 P. 2m

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 Clarence A. Murray
Licensed Embalmer No. 4011
P. O. Address St. Louis, Mo.

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.