

No. 2  
12-45  
-17-39  
X47070

FILED JAN 13 1947

1003

State File No. \_\_\_\_\_

Registrar's No. 11366

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

1. PLACE OF DEATH:

(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:  
Jewish Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4.5 minutes  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jennifer Baker

3. (b) If veteran name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F / 5. Color or race W

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 Aug. 30 1946  
(Month) (Day) (Year)

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

3	28		
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hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name Wright Baker

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

14. Maiden name Anna Sell Elliot

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

16. (a) Informant Wright Baker

(b) Address 2239 Helmar Granite City Mo.

17. (a) Burial (b) Date thereof 12-31-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia Mo.

18. (a) Signature of funeral director Mr. Lillian Sparks

(b) Address JAN 2 - 1947 Potosi Mo.

19. (a) \_\_\_\_\_ (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison <sup>999</sup>

(c) City or town Granite City <sup>11</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 2239 Helmar <sup>NK 0</sup>  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28  
year 1946 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from 8:50 PM.  
12/28, 1946, to 9 PM. 12/28, 1946  
that I last saw her alive on 12/28, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Primary BRONCHOPNEUMONIA, Rt.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 107  
(Include pregnancy within 3 months of death)

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

Of autopsy BRONCHOPNEUMONIA

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 Bernard Schwitzman (M. D. or other)

Address 4500 Olive St. Date signed 12/31/46

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

MOTHER FATHER

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 *Murphy L. Lankford*

Licensed Embalmer No. *4236*

P. O. Address *Hot Springs, Ark.*

**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.**