DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 7 1947

Registration District No. 818

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 42340

Registrar's No. [illegible]

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

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: Barnes D (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 90 Days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Mad. 999

(c) City or town Granite City NR (If outside city or town limits, write "RURAL")

(d) Street No. 2242 Delmar (If rural, give location) 11

(e) Citizen of foreign country? American (Yes or No) 0

If yes, name country 2

3. (a) PRINT FULL NAME Louise Ead

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John

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

7. Birth date of deceased Oct (Month) 20 (Day) 1877 (Year)

8. AGE: Years 69 Months 2 Days 8 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name Not Known
13. Birthplace (City, town, or county) Sweden (State or foreign country)

MOTHER
14. Maiden name Not Known
15. Birthplace (City, town, or county) Sweden (State or foreign country)

16. (a) Informant Arnold Ead

(b) Address Granite City Ill

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

(c) Place: burial or cremation Sun Set Hill Madison Co. Ill

18. (a) Signature of funeral director [illegible]

(b) Address Granite City Ill

19. (a) DEC 30 1946 (Date received local registrar) J. F. Brodack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28 year 1946 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of neck of left Femur Arteriosclerosis when she fell from the rear bottom step of the back porch of her home in Granite City

Due to [illegible] on Sept 30 1946 about 2:00 O'clock P.M.

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 1 [illegible]
Of autopsy 1 [illegible]

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) Accident

(b) Date of occurrence Sept 30 1946

(c) Where did injury occur? 29 Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)

While at work? (e) Means of injury Cabinet

23. Signature Alfred Perry (M. D. or other)

Address [illegible] Date signed 12/30/46

(Licensed Embalmer's Statement on Reverse Side)

FEB 19 1947

Separate sheet attached

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.