

S. No. 2  
M-5-43  
7-5-17-39  
- I X3667

FILED DEC 23 1946 **318**

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution; Missouri Baptist  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 45 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_

(c) City or town St. Louis 19000  
(If outside city or town limits, write "RURAL") 17

(d) Street No. 720 N. Taylor  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel Roy

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 M

6. (b) Name of husband or wife Raphael Roy 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 17, 1890  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17<sup>th</sup> year 1946 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from Oct. 21-46 to Dec-17-46, 1946  
that I last saw her alive on Dec-17- 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 2 mos.

Due to Hypostatic Bronchopneumonia 4 days.

Other conditions (Include pregnancy within 5 months of death) \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

8. AGE: Years 56 Months 6 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Flint, Mich (City, town, or county) (State or foreign country) 1

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unknown

{ 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) a

{ 14. Maiden name Ethel White (City, town, or county) (State or foreign country)

{ 15. Birthplace Flint, Mich (City, town, or county) (State or foreign country) 1

16. (a) Informant Raphael Roy

(b) Address 720 N. Taylor Ave.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-19-46 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Harrigan & Sheehan

(b) Address 4415 Washington Bl.

19. (a) DEC 19 1946 (Date received) (b) J. F. Bredeck (Registrar's signature)

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? OV

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature O.O. Smith M.D. (M. D. number) \_\_\_\_\_  
Address 536 N. Taylor Ave. P Date signed 12/18/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
41707

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**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 John S. Remmelby  
Licensed Embalmer No. 4194

P. O. Address.....

**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.**