

No. 2
-12-45
5-17-39
I X47070

FILED MAR 24 1947
#5588 318

1003

Registrar's No. 2584

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Stark
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME FANNIE STOTLER

3. (b) If veteran, name war No

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 Walter Stotler

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

7. Birth date of deceased February 9 1857
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|----------|----------------------|
| <u>90</u> | <u>1</u> | <u>1</u> | hr. _____ min. _____ |

9. Birthplace Rochester N. York
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER, FATHER {

12. Name William Cramond

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

14. Maiden name Eliza Smith

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

16. (a) Informant Mrs. Birdie Richards

(b) Address 4531 West Pine

17. (a) Burial (b) Date thereof 3-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4200 Washington Blvd.

19. (a) MAR 11 1947 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osceola

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

off Street No. 3853 Botanical Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th
year 1947 hour 6:45 minute _____ P.M. _____

21. I hereby certify that I attended the deceased from 3/7/47
_____, 19____, to 3/10/47, 19____;
that I last saw h. im alive on 3/10/47, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Arteriosclerotic heart disease

Due to _____

Due to _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. M. Z. [unclear] (b) 3/10/47
1515 Lafayette
Address _____ Date signed _____

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

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 Elmo R. Cadwell

Licensed Embalmer No. 4077

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.