

Registration District No. **318** Primary Registration District No. **1003**

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

**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:  
City Sanitarium  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5yrs 6mcs 9das  
 In this community 7 years  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County 000  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3936 Washington Ave  
City Sanitarium  
 (If in institution)  
 (e) Citizen of foreign country? yes (Yes or No)  
 If yes, name country Switzerland

**3. (a) PRINT FULL NAME JACOB ELMER**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced sep.  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased not known  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>abt - 77?</u>				hr. min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name not known 9  
 13. Birthplace not known (State or foreign country)  
 14. Maiden name not known  
 15. Birthplace not known (State or foreign country)

16. (a) Informant Helma Singler  
 (b) Address 5400 Arsenal St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery

18. (c) Signature of funeral director Cullinane Bros.  
 (b) Address 3320 N. Kingshighway Blvd.

19. (a) AUG 12 1947 (Date received local certificate)  
J. F. Brodeur (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH, Month August day 11th  
 year 1947 hour 12:10 minute P. M.

21. I hereby certify that I attended the deceased from May 1, 1945, 19\_\_\_\_, to August 11, 1947  
 that I last saw him alive on August 11, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arteriosclerotic Heart Disease 1945x  
Generalized Arteriosclerosis 10yrsx.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy No.

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 Paul T. Hartman (M. D. or other)  
 Address 5400 Arsenal Date signed 8/11/47

Duration  
 1945x  
 10yrsx.  
 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 Fred Frick

Licensed Embalmer No. 3186

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.**