No. 2
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-17-39

#78017

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32429

Registrar's No. 9258

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town ST. LOUIS CITY HOSPITAL (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 0 (If not in hospital or institution, write street number or location)

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

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ARO

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

(d) Street No. 4442 Olive St (If rural, give location) 9

19

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

If yes, name country

3. (a) PRINT FULL NAME ALICE GRAY DANFORD

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 Decessed

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

7. Birth date of deceased March 4, 1869 (Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 0 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown 9
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown 9
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant M. E. Cuthbertson

(b) Address Sparta Ill

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-6-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Sparta, Ill

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

(b) Address 4415 Washington, Ill

19. (a) OCT 6 1947 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th year 1947 hour 6:30 minute A M.

21. I hereby certify that I attended the deceased from 9/30/47, 19, to Oct. 4th 1947 that I last saw her alive on Oct. 4th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, subarachnoid, acute, severe

Due to Arteriosclerosis, cerebral and generalized.

Due to Hemorrhage, Subarachnoid, Acute Severe. Arteriosclerosis, Cerebral and generalized

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

Duration

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Warren B. Miller (M. D. or other)

Address 1515 Lafayette Date signed 10/4/47

Warren B Miller

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.