

U.S. DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **43005**  
Registrar's No. **11581**

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **De Paul Hospital**  
(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)

3. (a) PRINT FULL NAME **Emma Farmer**  
3. (b) If veteran, name war.....  
3. (c) Social Security No. ....

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced, **Widow**  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased: **March 29 1887**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**80 8 20** hr. min.

9. Birthplace: **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **At Home**

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

15. Birthplace: **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **John Farmer**  
(b) Address: **4468 Margaretta Ave.**

17. (a) **Burial** (b) Date thereof: **12/22/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Calvary**

18. (a) Signature of funeral director: **Stroot-Carroll**

(b) Address: **4600 Natural Bridge Ave**

19. (a) **DEC 19 1947** (b) **J.F. Brudeck**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **St. Louis**  
(c) City or town: **St. Johns Station**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **8708 Ezra Ave.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **19**  
year **1947** hour **3** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **Jan 1944**  
to **12-18-47**, 19....., to....., 19.....  
that I last saw her alive on **12-18-47**, 19.....  
and that death occurred on the date and hour stated above.  
Duration

Immediate cause of death: **Carcinoma of bladder (urinary)**

Due to..... **52**

Due to..... **Chronic Myocarditis 5 yrs**

Other conditions..... (Include pregnancy within 3 months of death)  
**Ca of bladder (urinary)**

Major findings: **Ca of bladder (urinary)**  
Of operations.....  
Of autopsy.....

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?..... (Specify means of injury)  
23. Signature: **Albert J. Brudeck** (M. D. or other) **0**  
Address: **7210 Natural Bridge** Date signed: **12-19-47**

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

MOTHER FATHER

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.....

*J. Allen Davis*

Licensed Embalmer No.....

*4083*

P. O. Address.....

*St Louis*

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.