

No. 2  
-1/47  
17-39

FILED APR 7 1948  
Registration District No. **0008**

Primary Registration District No. ....

Registrar's No. ....

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: **CITY HOSPITAL, 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.....

(c) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1547 CALIFORNIA AV. 9**  
**23**  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) **0**

If yes, name country.....

3. (a) PRINT FULL NAME **MARY REEVES,**

3. (b) If veteran, name war.....

3. (c) Social Security No. **3**

4. Sex **FE** / 5. Color or race **WI.**

6. (a) Single, widowed, married, divorced..... **DIVORCED**

6. (b) Name of husband or wife.....

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

7. Birth date of deceased **JUNE 2 1906**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **27**  
year **1948** hour **7** minute **22** p.M.

21. I hereby certify that I attended the deceased from.....  
....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**bronchopneumonia** **2 da**

Due to **malnutrition** **3 wk**

Due to **Seneca ceroid** **years**

Other conditions **Gastro-intestinal hemorrhage** **week**  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

**41 9 25** ..hr. ....min.

9. Birthplace..... **ST. LOUIS MO.**  
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Housekeeper**

PHYSICIAN

Major findings:  
Of operations.....

Of autopsy.....

Underline the cause of which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name **CHARLES SCHMITZ**

13. Birthplace..... **Mo. 0**  
(City, town, or county) (State or foreign country)

14. Maiden name **DELIA ANGLIN**

15. Birthplace..... **Mo. 0**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Edward E. Smith**  
(b) Address **1547 California Av**

17. (a) **BURIAL** (b) Date thereof **MARCH 31-48**  
(Burial, cremation or inquest) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **E. J. Schner**  
(b) Address **3125 Lafayette Av**

19. (a) **MAR 29 1948** (b) **J. F. ...**  
(Date received local registrar) (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?..... (Specify type of place)

While at work?..... (e) Means of injury..... **0**

23. Signature **John W. Murphy, Jr. MD** (M. D. or other).....  
Address **1515 Lafayette** Date signed **3-28-48**

WRITE PLAINLY—USING 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.....

Licensed Embalmer No..... *4653*.....

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.