

FILED NOV 12 1948 **318**

1003

Registration District No.

Primary Registration District No.

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 Hos. 1209 N. 13th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1209 N. 13th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SARAH CANTER

3. (b) If veteran, name war..... 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1948 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from 1943

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

19..... to 19.....
that I last saw him alive on Oct 29 1948
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Myocarditis 3 yr.

8. AGE: Years 70 Months Days If less than one day

Due to Cerebral Anemia

9. Birthplace: (City, town, or county) Russia (State or foreign country)

Due to

10. Usual occupation Housewife

Other conditions (include pregnancy within 3 months of death)

11. Industry or business Housework

Major findings: Of operations

12. Name Abraham

Of autopsy

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

PHYSICIAN

14. Maiden name Sarah

Underline the cause of which death should be charged statistically.

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

22. If death was due to external causes, fill in the following:

16. (a) Informant Williams Canter

(a) Accident, suicide, or homicide (specify).....

(b) Address 1209 N. 13th St.

(b) Date of occurrence.....

17. (a) Bureau (b) Date thereof 10-1-48

(c) Where did injury occur? (City or town) (County) (State)

(c) Place: burial or cremation Beth Hayslode Hospital

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

18. (a) Signature of funeral director Joseph Handke

While at work? (e) Means of injury

(b) Address 5010 Enright

23. Signature J. O. Reiter (M. D. or other)

19. (a) NOV 1 1948 (b) J. B. Blanton

Address 2505 N. Florissant Date signed 10-31-48

(Date received local registrar) (Registrar's signature)

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. B. Crenshaw

Licensed Embalmer No. *3669*

P. O. Address *5010 Enright*

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.