

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32809

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis, Mo.** (d) Street No. **2718 Mc Causland** St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Nicholson

(a) Residence, No. **2718 Mc Causland** St. **4** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John Nicholson**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 1, 1861**
 7. AGE YEARS **76** MONTHS **8** DAYS **20** If LESS than 1 day, ... hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housework**
 9. Industry or business in which work was done, as saw mill, bank, etc. **At home**
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.** (STATE OR COUNTRY)

13. NAME **Unknown Farrall**

14. BIRTHPLACE (CITY OR TOWN) **Ireland** (STATE OR COUNTRY)

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) **Ireland** (STATE OR COUNTRY)

17. INFORMANT **Thos. J. Nicholson** (ADDRESS) **2718 Mc Causland**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Mt. Lebanon** DATE **9/23/37**

19. FUNERAL DIRECTOR **Edith E. Ambuster** (ADDRESS) **1234 Manchester Ave**

20. **SEP 23 1937** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9/21/37** 19

22. I HEREBY CERTIFY, That I attended deceased from **Aug 5** 19**37** to **Sept 21** 19**37**
 I last saw **her** alive on **Sept 20** 19**37** Death is said to have occurred on the date stated above, at **530 P.m.**
 The principal cause of death and related causes of importance were as follows:

Hepatic

Other contributory causes of importance:

Cerebral Hemorrhage 9/20/37

Name of operation **none** Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury..... 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify **Hypertension** M. D.
 (Signed) **J. B. Beck** (Address) **68114 Grand Ave**

STATEMENT BY LICENSED EMBALMER

I, Florenz Eynck, Licensed Embalmer No. 1284

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Florenz Eynck

Licensed Embalmer No. 1284

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.)