

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 1939 **791**
Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County 11
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
En route City Hospital No. 1. **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Hines
8. (b) If veteran, name war No.
8. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hollon Hines
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Aug. 3rd. 1890
(Month) (Day) (Year)

8. AGE: Years 48 Months 11 Days 3
If less than one day hr. min.

9. Birthplace Litchfield Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name George kushton
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Clara Handy
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hollon Hines
(b) Address 1116 Talmadge Av.

17. (a) Removal
(Burial, cremation, or removal) (b) Date thereof. Girard Ill.
(Month) (Day) (Year)

18. (a) Signature of funeral director Josephine Matthews
(b) Address 4104 Industrial

19. (a) 1111 7 1939 (b) J. D. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 1
(c) City or town St. Louis **18**
(If outside city or town limits, write "RURAL")
(d) Street No. 1116 Talmadge Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th
year 1939 hour 10:58 P. minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Patron homicide
See Prisoning self
admitted and
Due to
Due to
7:00 and 10:30 P.M.
Other conditions (include pregnancy within 3 months of death) Suicide

PHYSICIAN
Major findings: Of operations _____
Of autopsy 164
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence 7/6/39
(c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, or industrial place, in public place? Home

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 7/11/39

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 *Reinhold K. Lohman*

Licensed Embalmer No. *3395*

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, above space should be left blank.