

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

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.

REG'D SEP 14 1939 **791**
Registration District No. **1008**

Primary Registration District 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:
2830a Park Ave **2**
(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 Missouri (b) County _____
(c) City or town St. Louis **23**
(If outside city or town limits, write "RURAL")
(d) Street No. 2830a Park Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Clara M. Wagley **240**
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Alfred H. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 24, 1866
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Miller
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Lucy Maxwell
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Maebee Williams
(b) Address 2830a Park Ave

17. (a) Burial (b) Date thereof 8/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem

18. (a) Signature of funeral director A. H. McLaughlin

(b) Address 2601 Lafayette Ave

19. (a) Aug 18 1939 (b) J. J. [Signature]
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17
year 1939 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from 5-11-1939
to 8-17-1939 to _____, 1939;
that I last saw him alive on 8-17, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency Duration 8 mos

Due to Chr. Int. Nephritis 8 mos

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
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) _____

(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. T. Walker (M. D. or other) _____
Address 2904 Park Ave Date signed 8/18/39

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 L. K. Casper

Licensed Embalmer No. 3633

P. O. Address 2372 Lafayette

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.