

REC'D OCT 14 1939
Registration District No. 791

1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. 18 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Elizabeth Manley 540

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased Unknown 23 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 25 If less than one day hr. min.

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

10. Usual occupation AT Home

11. Industry or business

12. Name John Bazzis

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Edna Cole

(b) Address 1450 North Market

17. (a) Burial (b) Date thereof 9 19 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director James Muller

(b) Address 5165 Wilmore Blvd.

19. (a) SEP 20 1939 (b) J. B. ...
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")
(d) Street No. 726 Clara St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18,
year 1939 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from August 2, 1939, to September 18, 1939,
that I last saw her alive on September 18, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dehydration
Cerebral Anoxia
Cerebral Hemorrhage

Due to _____

Other conditions (include pregnancy within 3 months of death) None

Major findings: Of operations _____

Of autopsy _____

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) (Means of injury)

23. Signature Samuel Beckman (M. D. or other) MD
Address 1515 Lafayette Date signed 9/19/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

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 *John Ketter*
Licensed Embalmer No. *3880*
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.