

Registration District No. _____

Primary Registration District No. _____

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.

1. PLACE OF DEATH:

(a) County 2
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
6180 Pershing Ave.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 10 Years (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Elizabeth Isabelle Humphrey ⁵⁷⁶

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 Widowed6. (b) Name of husband or wife Alfred H. Humphrey 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased May 22, 1853
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
86 5 22 hr. min.9. Birthplace France
(City, town, or county) (State or foreign country)10. Usual occupation At Home 7

11. Industry or business _____

12. Name Peter LaBarde 713. Birthplace France
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth LaSalle15. Birthplace France
(City, town, or county) (State or foreign country)16. (a) Informant's own signature J. Allen Humphrey(b) Address 6180 Pershing Ave17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-39
(Month) (Day) (Year)(c) Place: burial or cremation Glasgow, Mo.18. (a) Signature of funeral director Arthur J. Donnelly(b) Address 3840 Lindell Blvd S19. (a) NOV 18 1939 (Date recorded) (b) J. Z. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1
 (c) City or town St. Louis 5
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6180 Pershing Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14th
year 1939 hour 10 minute 40 P.M.21. I hereby certify that I attended the deceased from Nov. 13,
_____, 1939, to Nov. 14, 1939that I last saw h. ex alive on Nov. 14, 1939;
and that death occurred on the date and hour stated above.Immediate cause of death Arteriosclerotic
cardiovascular disease UncertainNephrosclerosis h "
Due to Arteriosclerosis

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 G. O. Brown (M. D. or other)Address 1325 S. Grand Blvd. Date signed _____

W. VanMatre

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 *W. VanMatre*
Licensed Embalmer No. *2825*
P. O. Address *4340 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.