

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.

JAN 12 1940

791
1008

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(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:
Deaconess Hospital.
(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

3. (a) PRINT FULL NAME Lois Ann Torbert.
3. (b) If veteran, name war NONE
3. (c) Social Security No. NONE
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 6th 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 22
If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name Arthur Torbert
13. Birthplace Houston, Texas
(City, town, or county) (State or foreign country)
14. Maiden name Mary Foster Hunt
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. E. Butler.

(b) Address 157 So. Maple, Ave.

17. (a) Burial. (b) Date thereof Dec 30 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director C. R. Hupton + Sons

(b) Address # 7233 Delmar Blvd.

19. (a) DEC 30 1939
(Date received local registrar) J. F. Butler

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis Mo. 12
(If outside city or town limits, write "RURAL")
(d) Street No. Usona Hotel.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28
year 1939 hour 10 minute A M.

21. I hereby certify that I attended the deceased from October, 1933 to Dec 28, 1939;
that I last saw her alive on Dec 27, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death: Obstruction, intestinal Duration 6 da

Due to leasurism of sigmoid

Due to Intestinal following ?
removing cancer removed 5 yrs ago

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 John C. Knight Int (M. D. or other) 1939
Address 940 Pine Blvdy Date signed Dec 28

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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis, Mo*

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.