

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.

Registration District No. 797

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County 3 St. Louis,  
(b) City or town St. Louis,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Masonic Home Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Eleven years, 11 months, 21 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County \_\_\_\_\_  
(c) City or town 12 St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5351 Delmar Boulevard  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINTED FULL NAME Mrs. Kate R. Skaggs

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 Widow

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

7. Birth date of deceased April 26th 1852  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 10 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Milton Vance

13. Birthplace Not known

14. Maiden name Sarah J. Onstott (City, town, or county) (State or foreign country)

15. Birthplace not known  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fannie Spence

(b) Address 5351 Delmar Blvd. St. Louis, Mo.

17. (a) Burial (b) Date thereof 2-28-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pinefontaine Cem

18. (a) Signature of funeral director Louis J. Bopp

(b) Address Hickwood Mo.

19. (a) FEB 27 1940 (b) J. F. Brudick  
(If received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27  
year 1940 hour 5.35 minutes A. M.

21. I hereby certify that I attended the deceased from January II, 1940, 19\_\_\_\_, to February 27 1940, that I last saw her alive on February 26 1940; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Carcinoma of Lung 3mths

Due to \_\_\_\_\_

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 John Vance (M. D. or other) \_\_\_\_\_

Address 5351 Delmar Blvd Date signed 2.27.40

**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.....

*John H. Meyer*  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*John H. Meyer*

Licensed Embalmer No. ....

*3285*

P. O. Address

*Hickwood Ma*

**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.**