

MARGIN RESERVED FOR BINDING

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.

V. S. NO. 4
50M-5-17-39
Rev. 5-17-39
11 X1951

Registration District No. **791**

Primary Registration District No. **1003**

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:
DePaul 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis **12**
(If outside city or town limits, write "RURAL")
 (d) Street No. 4812 Fountaine Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Emma D. Bishop

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 Cyrus Bishop 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 22 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>4</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Freeman Drew

18. Birthplace Vermont
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Sanderson

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

16. (a) Informant's own signature Harold D. Bishop

(b) Address 4812 Fountain Ave.

17. (a) Burial (b) Date thereof 3-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cen.

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) MAR 14 1940 (b) J. B. Backer
(Date received local registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 13
 year 1940 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from Feb 1
1940 to Mar 13 1940
 that I last saw her alive on Mar 13 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Renal Failure Due to
pneumonia, bronchial Bronchitis
 Duration 4 days 2 wks. 4 wks.

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

Major findings: 707W
 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 J. B. Backer (M. D. or other) 1
 Address 3437 Delmar Date signed 3-14-40

10:00, morning
5:17
2-3- Med + Dinner, Under
7-8 PM

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: Warren A. Casper

Licensed Embalmer No. 3534

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.