

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.

MAILED 15 1940 791

Primary Registration District No. 1003

Registrar's No. 3858

**1. PLACE OF DEATH:**  
 (a) County St. Louis, Mo  
 (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: BARNES HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

8. (a) PRINT FULL NAME Eva Rednour, 356  
 8. (b) If veteran, name war No. 8. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Albert 6. (c) Age of husband or wife if alive 39 years  
 7. Birth date of deceased March 15 1911  
 (Month) (Day) (Year)

8. AGE: Years 29 28 Months 1 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

**MOTHER FATHER**  
 12. Name Albert Harrell  
 13. Birthplace Unknown  
 (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 Albert Rednour  
 (b) Address Willisville, Illinois.

17. (a) Removal (b) Date thereof 4-30-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Willisville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe  
 (b) Address 4700 Washington Ave.

19. (a) APR 29 1940 (b) J. F. [Signature]  
 (Date received local registrar) (Signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Illinois (b) County Perry  
 (c) City or town Willisville NR  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month April day 28  
 year 1940 hour 4 25 minute P. M.  
 21. I hereby certify that I attended the deceased from April 27  
1, 1940, to April 28, 1940  
 that I last saw her alive on April 28, 1940,  
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Shock</u>	
Due to <u>Hemorrhage</u>	
Due to _____	
Other conditions <u>Retained placenta @ full term child del 3 wks ago @ placenta</u>	
Major findings: Of operations <u>cesary @ Sec. caecum, warts</u>	
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?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature J. M. Parker (M. D. or other) MD  
 Address BARNES HOSPITAL Date signed 4/28/40

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Albert G. Kapp*

Licensed Embalmer No. *3971*

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.**