

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. 791

Primary Registration District No. 1003

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: 4431 S. Broadway 2  
(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 MARTHA RICE 20  
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 Arthur  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 24 1869  
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo. D  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

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

**MOTHER**  
12. Name Mrs. Wiley  
13. Birthplace Scotland  
(City, town, or county) (State or foreign country)

**FATHER**  
14. Maiden name Mary Graves  
15. Birthplace England  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Jones  
(b) Address 4431 S. Broadway

17. (a) Cremation (b) Date thereof 7-23-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Pictet Cemetery

18. (a) Signature of funeral director C. Hoffmeister  
(b) Address 7814 S. Broadway

19. (a) July 29 1940 (b) J. F. Braddock  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis 15  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 4431 S. Broadway  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month July day 19  
year 1940 hour 10 minute 15 A. M.  
21. I hereby certify that I attended the deceased from June 1939 to July 17 1940  
that I last saw her alive on July 16 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 1 yr  
Chronic Interstitial Nephritis 6 mo  
Pulmonary oedema 10 days  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations no  
Of autopsy no

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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) (a) Means of injury \_\_\_\_\_  
23. Signature Chas. Hymus (M. D. or other) MD  
Address 3720 Washington Date signed 7/29/40

Duration \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

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**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 *Edwin H. Lubinger*

Licensed Embalmer No. *4049*

P. O. Address *6164 Shippwa*

**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.**