

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

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

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: \_\_\_\_\_  
2223 Cherokee St. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County \_\_\_\_\_

(c) City or town. St. Louis 24  
(If outside city or town limits, write "RURAL")

(d) Street No. 0 2223 Cherokee St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Cora Myrtle Kaber 160

3. (b) If veteran, name war. No. 3. (c) Social Security No. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1940 hour 12:30 minute A M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Dec. 5 1881  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 2 1940 to July 23 1940 that I last saw her alive on July 23 1940 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>7</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Charcotomay Right Lung

Due to (2) Diabetes mellitus 19 year

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

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

10. Usual occupation Housewife

Other conditions H7  
(Include pregnancy within 3 months of death)

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

12. Name Henry Allen Clark

13. Birthplace Bowling Green Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Alice White

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

16. (a) Informant Jerome Satterlee

(b) Address 201 E. Edward Litchfield, Ill.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) Removal (b) Date thereof 7-25-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Ridge, Ill.

(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? \_\_\_\_\_

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUL 23 1940 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature Adam R. Youngman (M. D. or other) \_\_\_\_\_

Address 5439 Bravais Date signed 7/23/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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

*J. S. Sullivan*

Licensed Embalmer No. 1172

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, fact should be so stated above.**