

No. 2
13-40
17-39
X23189

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: 5865 Cates Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis **5**
(If outside city or town limits, write "RURAL")
(d) Street No. 6126 Plymouth Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30
year 1940 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from July 7, 1939, to Dec. 30, 1940
that I last saw her alive on Dec. 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Duration: 1 mo.
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 Amelia P. White (M. D. or other) **1**
Address 1194 Hodiamont Ave Date signed 12/29/40

3. (a) PRINT FULL NAME Amelia K. Holmes

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Dec. 25, 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 5 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Mitchell Walters

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Catherine Kaiser

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

16. (a) Informant Richard J. Holmes

(b) Address 6126 Plymouth Ave.

17. (a) Burial (b) Date thereof 1/2/40/
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) DEC 31 1940 (b) J. F. Brudeck
(Date entered for record) (Registrar's signature)

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

Dr. O. White
1196a Hodiament Ave.

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.....


.....
Licensed Embalmer No..... 3225

P. O. Address..... 1125 Hodiament Ave

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.