

APR 9 1941

Registration District No. 754

Primary Registration District No. 200

Registrar's No. 685

96
0
0

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mound St. Rose Sanatorium #4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 years (Specify whether
In this community 4 days years, months or days)

3. (a) PRINT FULL NAME Dr. M. Josephine (Dunford)

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

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

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

7. Birth date of deceased Dec. 2 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 26 If less than one day - hr. - min.

9. Birthplace Somersetshire England #4
(City, town, or county) (State or foreign country)

10. Usual occupation (Artist) Religion

11. Industry or business convent

12. Name Richard Dunford

13. Birthplace ? England #4
(City, town, or county) (State or foreign country)

14. Maiden name Anna M. Proft

15. Birthplace England #4
(City, town, or county) (State or foreign country)

16. (a) Informant Sister M. Sylvester

(b) Address 1100 Bellvue Rich. Heights

17. (a) Burial (b) Date thereof 3-31-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thomas J. Dunton

(b) Address 1519 So Grand Ave

19. (a) APR 28 1941 (b) T.R. Meadors XPN
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96
(c) City or town Rural Lemay 0
(If outside city or town limits, write "RURAL")
(d) Street No. Mound St. Rose Sanatorium 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1941 hour 12 minute 26 a. M.

21. I hereby certify that I attended the deceased from Dec 1940, 19 , to 3-28-41, 19 ;
that I last saw her alive on 3-28-41, 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease

Due to -
Due to -

Other conditions Tracheal stricture 2 yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations 93d
Of autopsy -

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 B. E. Gerson (M. D. or other) 11
Address 9101 S. Broadway Date signed 3-28-41

Duration
5 yrs
2 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 _____

John Ketter

Licensed Embalmer No. 3880

P. O. Address St. Louis Mo.

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.