

Registration District No. 789

Primary Registration District No. 900

Registrar's No. 1323

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Manchester
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Manchester Nursing Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 1/2 months
 In this community 3 1/2 months
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis, 9th
 (c) City or town Sadue Village
 (If outside city or town limits, write "RURAL")
 (d) Street No. Log Cabin Lane
 (If rural, give location)
 (e) Citizen of foreign country? Yes (Yes or No)
 If yes, name country Hungary

3. (a) PRINT FULL NAME

Annie Barl

3. (b) If veteran,

name war none

3. (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 Ceza Barl

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased ? ? 1893
 (Month) (Day) (Year)

8. AGE: Years 48 50 Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ceza Barl

(b) Address Sadue Village, Mo.

17. (a) Burial (b) Date thereof 6-26-1941
 (Place of burial or cremation) (Month) (Day) (Year)

(c) Place: burial or cremation Manchester, Mo.

18. (a) Signature of funeral director Schrader Funeral Home

(b) Address Ballwin, Mo.

19. (a) TR Meyer (b) TR Meyer
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
 year 1941 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from March 10
1941 to June 23 1941
 that I last saw her alive on June 22 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix
(Adenocarcinoma) Over 3 1/2 mo

Due to 48.0

Due to 48.0

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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 D. C. Campbell (M. D. or other)

Address 112 8th Hamilton Date signed June 24/41

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 *Theo. Schrader*
Licensed Embalmer No. *3066*
P. O. Address *Dallwin*

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.

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1323

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town _____
 (c) Name of hospital or institution: _____
 (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 Annie Barl
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE:	Years	Months	Days	If less than one day
				min.

9. Birthplace: _____ (City, town, or county) _____ or foreign country

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name _____
 13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____
 15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant's own signature _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 6-24-41 (b) TR Meyer M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (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 June day 23
 year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Duration _____
 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 _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTAL

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.

5-22701

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.....

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.