

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:
5448 Cabanne 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 36 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL")
(d) Street No. 5448 Cabanne Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 17
year 1941 hour 8 minute 55 A. M.
21. I hereby certify that I attended the deceased from May 28th
1941 to September 17 1941;
that I last saw her alive on September 16 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Myopertensive
Cardiovascular
disease
Due to _____
Due to _____

Duration
one
year

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

Major findings:
Of operations _____
Of autopsy aut

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 D

23. Signature Augustus P. Mensch (M. D. or other)
Address 306 S. 1st St. St. Louis Date signed Sept 17 1941

3. (a) PRINT FULL NAME Sister Aurelia Collyer.

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

4. Sex Female 5. Color or race White 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. March 4, 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 6 13 _____ hr. _____ min.

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

10. Usual occupation Religious.

11. Industry or business _____

12. Name Frank A. Collyer.

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

14. Maiden name Adah Burton.

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

16. (a) Informant Sister Mary Martha.

(b) Address 5448 Cabanne Ave.

17. (a) Burial. (b) Date thereof Sept. 18, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) SEP 18 1941 (b) J. J. Beedock
(Date received local registrar) (Registrar's signature)

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

70
7

*Dr. Dr. Marshall
Humboldt Bldg*

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.