

FILED FEB 24 1942
791

Registration District No. _____

Primary Registration District No. **10**

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:
3906 Lindell Blv'd ✓
(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)

2. USUAL RESIDENCE OF DECEASED:

Missouri
(a) State _____ (b) County _____
(c) City or town **St. Louis** **19** ✓
(If outside city or town limits, write "RURAL")
(d) Street No. **3906 Lindell** **6**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **RITA MARK**

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

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Gene Mark** 6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **May 5 1893**
(Month) (Day) (Year)

8. AGE: Years **48** Months **8** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **George Laible**
13. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Jessie Cloin**
15. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Gene Mark**
(b) Address **3906 Lindell Blv'd**

17. (a) **Cremation** (b) Date thereof **Jan-26-42**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove Crematory**

18. (a) Signature of funeral director **A. Krow R. U. Co**
(b) Address **2707 N. Grand Blv'd**

19. (a) **J. P. Brudack** (b) **J. P. Brudack**
(Date received local registrar's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **24**
year **1942** hour **6** minute **45** a. M.

21. I hereby certify that I attended the deceased from **Nov 7** 19 **41** to **Jan 24** 19 **42**
and that death occurred on the date and hour stated above.

that I last saw **her** alive on **Jan 22** 19 **42**

Immediate cause of death _____ Duration _____

Carcinomatous Primary in breast.

Due to **Metastasis to Orbit left**

Due to **and brain**

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 **Ashie Blair** (M. D. or other) _____
Address **3720 Washington** Date signed **4/24/42**

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

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

Paul F. Kullenberg

Licensed Embalmer No.

2631

P. O. Address

2707 N. Shaw

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.