

FILED MAR 17 1942

1003

State File No.

Registrar's No. 1343

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Elisha Masters

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, ~~married~~, divorced Widowed

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased JUNE (Month) 5 (Day) 1862 (Year)

8. AGE: Years 79 Months 7 Days 27 If less than one day hr. min.

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

10. Usual occupation SHOEMAKER

11. Industry or business

12. Name UNKNOWN

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 PAUL BETTENVIELL

(b) Address 1236 ARCH TERRACE

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director St. Matthews

(b) Address 4600 Natural Bridge

19. (a) FEB 19 1942 (Date received local registrar) (b) J. F. Brubaker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 11, year 1942 hour 11:00 minute P. M.

21. I hereby certify that I attended the deceased from January 20, 19 42 to February 11, 19 42

that I last saw him or her alive on February 11, 19 42 and that death occurred on the date and hour stated above.

Immediate cause of death gangrene Both Legs

Chronic Thrombosis

Due to Arteriosclerosis

Due to

Other conditions

Major findings: gangrene Both Legs

Of operations None

Of autopsy None

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)

(e) Means of injury

23. Signature L. V. Mulligan (M.D.)

Address 1515 Lafayette Avenue Date signed 2/13/42

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

MOTHER FATHER

Duration

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 F. H. Street.....

Licensed Embalmer No. 2265.....

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, fact should be so stated above.