

FILED MAY 18 1942
784

Registration District No.

Primary Registration District No. 200

Registrar's No. 1061

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") ✓
(d) Street No. 4600 Maryland Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1942 hour 3 minute 10 P.M.
21. I hereby certify that I attended the deceased from March 15, 1942
1942 to May 13, 1942;
that I last saw h. alive on May 13, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis,
recurrent

Due to: Central arteriosclerosis

Due to: 83%

Other conditions: Hypertension
(Include pregnancy within 6 months of death)

Major findings: Psychosis with central arteriosclerosis

Of operations: _____
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 Curtis Abbott Ray (M. D. or other) MD.
Address St. Vincent Pontianum Date signed 5-13-42

3. (a) PRINT FULL NAME Anna Sarah Miller

3. (b) If veteran, name war ***** 3. (c) Social Security No. *****

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

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

7. Birth date of deceased August 12 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 8 1 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name ????? Hughes

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

14. Maiden name Ellen Cartwright

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

16. (a) Informant Mrs. Lorraine M. Alan

(b) Address 4600 Maryland Ave

17. (a) Removal (b) Date thereof May 14 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beatrice Nebraska

18. (a) Signature of funeral director Petz Brothers

(b) Address 3029 Lafayette Ave
19. (a) MAY 14 1942 (b) C. H. McDevon
(Date received local registrar) (Registrar's signature)

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

76
00

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 Frank J. Owens

Licensed Embalmer No. 2245

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, fact should be so stated above.