

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:  
5072 Cabanne Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution .....  
In this community Lifetime (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lillie B. White  
3. (b) If veteran, name war no 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 28 1855  
7. Birth date of deceased. Dec. 28 1855  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 6 19 hr. min.

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

10. Usual occupation At home

11. Industry or business .....

12. Name Col. Rob't White

13. Birthplace Green Co. Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Isabelle White

15. Birthplace Wheeling W. Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara N. Houston  
(b) Address 5072 Cabanne Ave

17. (a) Burial (b) Date thereof 7 18 42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Wagoner Und. Co.  
(b) Address 3621 Olive St.

19. (a) JUL 17 1947 J. F. Bedeck  
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000  
(a) State Missouri (b) County 12  
(c) City or town St. Louis 9/12  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5072 Cabanne  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 17  
year 42 hour 12:30 minute PM M.

21. I hereby certify that I attended the deceased from May 17  
19 42 to July 17 19 42  
that I last saw her alive on June 7 24 19 42  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-vascular  
renal disease

Due to .....

Due to .....

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations .....

Of autopsy None

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? .....

(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 0

23. Signature Dr. S. A. Munsch (M. D. or other) .....

Address 637 N Grand Date signed 7/17/42

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

000  
17  
9

MOTHER FATHER

Dr. Munnick  
813 Mo Theatre 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 *Neville B. Frohwitter*

Licensed Embalmer No. 3696

P. O. Address 3621 Olive St.

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.