

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 727

Registration District No. 101

Primary Registration District No. 101

96
329
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
99 Aberdeen Pl.
(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:
 (a) State Mo (b) County St. Louis
 (c) City or town Clayton
(If outside city or town limits, write "RURAL")
 (d) Street No. 99 Aberdeen Pl.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 0

3. (a) PRINT FULL NAME Emily Hommel
 3. (b) If veteran, name war none
 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 July 30. 1891
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|-----------|----------|-----------|------|----------------------|
| <u>51</u> | <u>7</u> | <u>25</u> | | _____hr. _____min. |

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

10. Usual occupation Domestic

11. Industry or business _____

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant See next page

(b) Address 99 Aberdeen Pl

17. (a) Anatomical Board in St. Louis 3/27/43
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director W. R. B. ...
 (b) Address 3500 ...

19. (a) 3-30-43 (b) E. G. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25
 year 1943 hour 1 minute _____ P. M.

21. I hereby certify that I attended the deceased from 8 a.m.
March 25, 1943, to March 25, 1943
 that I last saw him alive on March 25, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Duration 5 days

Due to Vascular hypertension ?

Due to _____

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

Major findings:
 Of operations _____
 Of autopsy fixed
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

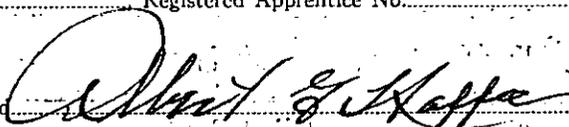
(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 23. Signature Samuel B. Grant (M. D. or other) M.D.
 Address 114 N. Taylor Ave Date signed 3/27/43

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



Licensed Embalmer No. 2971

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.