

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3858

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:
3729 Olive St.
(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.....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3729 Olive St.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Nellie Lunsford

3. (b) If veteran, name war.....

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased. June 24 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

49 10 0 hr. min.

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

10. Usual occupation House Wife

11. Industry or business.....

MOTHER FATHER { 12. Name David Mc Dowell

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

14. Maiden name Ellen Connelly

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

16. (a) Informant Wm. Lunsford

(b) Address 3729 Olive St.

17. (a) Burial (b) Date thereof 4-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Wm. Schumacher

(b) Address 3015 Meramec St.

19. (a) APR 26 1943 (b) J. F. Medeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th.
year 1943 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6 P.M.
Apr 24th 1943 to 7:30 P.M. 1943
that I last saw him alive on Apr 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (Left Hemiplegia)

Due to Arteriosclerosis

Due to.....

Other conditions (Include pregnancy within 3 months of death)
8/3

Major findings: 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)

(c) Means of injury.....

23. Signature Charles F. Wilson (M. D. or other)
Address 3812 1/2 Olive St. Date signed 4/28/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8-9 AM. - 12-1 PM. - 4-5 PM.

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.....

Clarence Rochow

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Clarence Rochow

Licensed Embalmer No.....

3093

P. O. Address.....

3013 Meramec 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.