

FILED AUG 8 1943 318

Registration District No.

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis.**
(b) City or town **St. Louis.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Months.**
(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. **4550 Pershing Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Annie Chapman Cornet.**

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

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced, **Widow.**

6. (b) Name of husband or wife **Henry L. Cornet.** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **November 26, 1863**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 0 hr. min.

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

10. Usual occupation **At Home.**

11. Industry or business.....

12. Name **Christopher Chapman.**

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

14. Maiden name **Mary Sullivan.**

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

16. (a) Informant **Harry Cornet.**

(b) Address **4550 Pershing Ave.**

17. (a) **Burial.** (b) Date thereof **7-28-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd**

19. (a) **JUL 27 1943** (b) **J. P. Bussard**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **26th.**
year **1943** hour **2** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **April 29**, 19**30**, to **July 26**, 19**43**.
that I last saw her alive on **July 26**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **36 hours**

Due to **general arterio sclerosis** **20 years**
3 previous attacks of cerebral artery block or break

Other conditions **Diabetes mellitus** **10 years +**
(Include pregnancy within 3 months of death)

Major findings: **61**
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.....
3. Signature **Walter Fischer** (M. D. or other) **0**
Address **3720 Washington** Date signed **7-27-43**

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

MOTHER FATHER

Dr. Friedman
3720 Washington
2-4

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.