

FILED NOV 1 1943
Registration District No. **318**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital
(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)

3. (a) PRINT FULL NAME **Oma Lee Ophia Stephens**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Neute Stephens** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **February 17 1891**
(Month) (Day) (Year)

8. AGE: Years **52** Months **8** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace **Lodi Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At Home**

MOTHER FATHER { 12. Name **Thomas Baker**
13. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jerry Wernecker**

(b) Address **Fredericktown, Missouri**

17. (a) **Burial** (b) Date thereof **10/22/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fredericktown, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **Oct 22 1943** (b) **J. J. Budick**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Madison**
(c) City or town **Fredericktown**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **21**
year **1943** hour **4** minutes **55 P. M.**

21. I hereby certify that I attended the deceased from **10-4** 19**43**, to **10-21** 19**43**
that I last saw her alive on **Oct 21** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Embolus** Duration **10 Minutes**

Due to **falling operators for ventral hernia 10/1/43**

Due to _____

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

Major findings: **Ventral Hernia**
Of operations _____
Of autopsy **none made**

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)
(e) Means of injury _____
23. Signature **John D. Hayward** (M. D. or other)
Address **Metropolitan Bldg** Date signed **10/22/43**

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

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.....

W. W. Wilkins

Licensed Embalmer No. *3575*

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.