

NOV 20 1943 **318**

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **9935**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 mo. 12 days**
(Specify whether years, months or days)

In this community **20 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Laura Waters**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **female** 5. Color or race **oil**

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

6. (b) Name of husband or wife **Peter W. Waters** 6. (c) Age of husband or wife if alive **62** years

7. Birth date of deceased **not known**
(Month) (Day) (Year)

8. AGE: Years **42** Months **4** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **house wife**

11. Industry or business **not known**

12. Name **not known**

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

14. Maiden name **not known**

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

16. (a) Informant **Peter W. Waters**

(b) Address **1410 N. Garrison**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-15-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Eggenwood**

18. (a) Signature of funeral director **L. Waters**

(b) Address **27690 Boulevard**

19. (a) **NOV 13 1943** (Date received local registrar's certificate) **J. D. Brueck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

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

(d) Street No. **1410 N. Garrison**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **11,**
year **1943** hour **12** minute **38 A. M.**

21. I hereby certify that I attended the deceased from **September 30,** 1943, to **November 11,** 1943, that I last saw her alive on **November 11,** 1943, and that death occurred on the date and hour stated above.

Immediate cause of death **Uterine Carcinoma with generalized metastasis of abdomen**

Due to _____

Due to _____

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

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)

(e) Means of injury _____

23. Signature **S. E. Smith** (M. D. or other) _____

Address **2601 Webster** Date signed **11-12-43**

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

MOTHER {

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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. *2498*

P. O. Address *2769 Chouteau*

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.