

FILED MAR 1 1944  
378

1003

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County ST. LOUIS MO.  
(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: DE PAUL HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS  
(c) City or town PINE LAWN  
(If outside city or town limits, write "RURAL") ONR  
(d) Street No. 4236 Pavenwood  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17  
year 44 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from April 1, 1942 to Feb 17, 1944  
that I last saw him alive on Feb 17, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of breast Duration 2 yrs

Due to \_\_\_\_\_  
Due to 50  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

3. (a) PRINT FULL NAME DR. ANNA BELLE WHITMER

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife GUSTAVE WHITMER 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased FEB 19 1900  
(Month) (Day) (Year)

8. AGE: Years 43 Months 11 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation CHIROPRACTIC DOCTOR

11. Industry or business \_\_\_\_\_

12. Name GEVERT H. WINTJEN

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

14. Maiden name MARY ANDERSON

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

16. (a) Informant Dr. W. J. Nelson

(b) Address 9112 Meadowbrook Lane

17. (a) REMOVAL-MOTOR (b) Date thereof 2-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HARDIN, ILLS.

18. (a) Signature of funeral director TRUTH CENTER MORTUARY

(b) Address 4024 LINDELL BLVD.

19. (a) FEB 18 1944 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 A F Lerner (M. D. or other) \_\_\_\_\_  
1279 N Kingshighway Date signed 2-18-44

**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.....

*V. O. Morris*

Licensed Embalmer No.....

*3360*

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.**