

FILED MAR 27 1944
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2652**

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:
Mo. 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 6296 Bartmer Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louis C. Elkins.
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sarah Elkins 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Feb. 20, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 0 27 hr. _____ min.

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

10. Usual occupation Watchman

11. Industry or business _____

MOTHER { 12. Name Taylor Elkins
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Schokley
15. Birthplace Unkown
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Elkins

(b) Address 6300 Bartmer Ave.

17. (a) Burial (b) Date thereof Mar. 21/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) MAR 20 1944 (b) J. F. Branch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18
year 1944 hour 3.00 minute A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Apoplexy

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)
_____ Means of injury _____

23. Signature W. H. Perry (M. D. or other) _____

Date signed 3/22/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

CITY CORONER

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. 3225

P. O. Address 1125 Hodiement Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.