

FILED APR 13 1944

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2155**

I. 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: 4445th Ashland 1
(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) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
17
 (c) City or town St. Louis 710
(If outside city or town limits write "RURAL")
 (d) Street No. 4445th Ashland
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mary Hercules

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

4. Sex female 5. Color White 6. (a) Single, widowed, married, divorced married
 race White

6. (b) Name of husband or wife Robert Hercules 6. (c) Age of husband or wife if
 alive 71 years

7. Birth date of deceased aug 15 1874
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days 16 If less than one day
 hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Lucian Morehead

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

14. Maiden name Unknown

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

16. (a) Informant Mrs George Jasper
 (b) Address 4445th Ashland

17. (a) Burial (b) Date thereof April 4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Sam Miller
 (b) Address 5041 Delmar

19. (a) APR 4 1944 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st
 year 1944 hour 3 15 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1924
 1944 to April 1st 1944
 that I last saw her alive on March 31st 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Duration 4 hrs.

Due to Hypertension 1 year

Due to _____

Other conditions: 82
(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 Edwin Schreiber (M. D. or other) M.D.
 Address 3625 N. Chestnut Date signed 4-3-44

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

3635^a

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 Howard F. Rowland

Licensed Embalmer No. 3474

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, above space should be left blank.