

FILED SEP 8 1944
318

Registration District No. _____ Primary Registration District No. **1003**

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

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:
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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

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

(d) Street No. **4348 Olive Street**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Ethel M. Holley**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 4, 1893**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	51	5	18	hr. _____ min. _____

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Edward B. Holley**

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

14. Maiden name **Florence League**

15. Birthplace **Peoria Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edward B. Holley Jr.**

(b) Address **763 Walton Avenue**

17. (a) **Cremation** (b) Date thereof **Aug 24, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Crematory**

18. (a) Signature of funeral director **Shepard Funeral Home**

(b) Address **1167 Hamilton Avenue.**

19. (a) **AUG 24 1944** (b) **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **22**, 19**44**
year _____ hour **5:25** minute **P** M.

21. I hereby certify that I attended the deceased from **July 23**, 19**44** to **Aug 22**, 19**44**
that I last saw h. **or** alive on **July 23**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma lung, left** **6 mo**

Due to: **Carcinoma breast, left** **2 years**

Due to _____

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

Major findings: **50**
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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **[Signature]**

Address **402 S. Chestnut Blvd** Date signed **8-23-44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1944 FEB 21 10 21 AM

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 *Albert G. Hoffe*

Licensed Embalmer No. *2971*

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.