

FILED OCT 23 1944 18

Primary Registration District No. \_\_\_\_\_

Registrar's No. 8868

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

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;  
5916 West Park Ave  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000  
174

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 5916 WEST PARK AVE  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Emily Hoffmeister

3. (b) If veteran, name war No

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 17  
year 1944 hour 12:05 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from March  
3 1943, to 10-16 1944  
that I last saw her alive on 10-16 1944  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Henry 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: JAN 4 1970  
(Month) (Day) (Year)

Immediate cause of death Cerebral Thrombosis Duration 3 days

Due to Hypertension

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 83

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

74 9 13 hr. \_\_\_\_\_ min.

9. Birthplace OBINE COUNTY TENN  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWORK

11. Industry or business AT HOME

12. Name JASPER WHITE

13. Birthplace UNION CITY TENN  
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNION CITY TENN  
(City, town, or county) (State or foreign country)

16. (a) Informant GRACE RANDOLPH

(b) Address 5916 WEST PARK AVE

17. (a) BURIAL (b) Date thereof 10 20 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEM

18. (a) Signature of funeral director KRIEGER SHAWVER

(b) Address 225 S. Kings Highway

19. (a) OCT 19 1944 (b) J. F. Brecken  
(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 H. R. Bremer (M. D. or other) \_\_\_\_\_  
Address 4266 MANHURSTER Date signed \_\_\_\_\_

*Ms Brewer  
4266 & Massachusetts  
Je 3131*

**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 *Richard W. Stovard*

Licensed Embalmer No. *4007*

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.**