

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED NOV 15 1944
Registration District No. 318

Primary Registration District No. 1003

State File No. 9440
Registrar's No.

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:
Barnes 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 6 MONTHS years, months or days

3. (a) PRINT FULL NAME LINDA LOU KILLIAN
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 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: MAY 14 1944
(Month) (Day) (Year)

8. AGE: Years 5 Months 24 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace: ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____

12. Name JOHN KILLIAN
13. Birthplace EAST ST. LOUIS ILL
(City, town, or county) (State or foreign country)
14. Maiden name THELMA WOODCOCK
15. Birthplace ELLINGTON MO.
(City, town, or county) (State or foreign country)

16. (a) Informant John Killian
(b) Address 2717 N. LEFFINGWELL
17. (a) BURIAL (b) Date thereof 11-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director St. Louis Funeral Home
(b) Address 2205 St. Louis Ave
19. (a) NOV 7 1944 (b) J. F. Bessick
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17
(d) Street No. 2717 LEFFINGWELL (If rural, give location) 920
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 5
year 1944 hour 5 PM minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute enteritis
Other conditions Broncho pneumonia
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy as above

Duration 2
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 0
23. Signature Robert A. Moore MD. (M. D. or other)
Address 570 S. Euclid Date signed 11/6/44

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

113
17
9

MOTHER FATHER

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

John Ganosky

Licensed Embalmer No. 3398

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.