

BUREAU OF THE REGISTRAR
FILED NOV 30 1944

STANDARD CERTIFICATE OF DEATH

State File No.

9727

Registration District No.

318

Primary Registration District No.

1003

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: City Infirmery 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mo., 7 Days
(Specify whether
In this community LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 920 Mound
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

17
16
25

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14, 1944
year _____ hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept. 7, 1944
_____, 19____, to Nov. 14, 1944
that I last saw her alive on Nov. 14, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease
Duration _____

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy none

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 J. F. Breuch (M. D. or other) _____
Address 5800 Arsenal Date signed 11-15

3. (a) PRINT FULL NAME Lillie Wooddall

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 Separated

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

7. Birth date of deceased March 8 1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 6 If less than one day hr. _____ min. _____

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country) U.S.A.

10. Usual occupation Nil

11. Industry or business _____

12. Name John Brennen

13. Birthplace Ireland (City, town, or county) (State or foreign country) U.S.A.

14. Maiden name Marcella English

15. Birthplace England (City, town, or county) (State or foreign country) U.S.A.

16. (a) Informant M. Geasland

(b) Address 5800 Arsenal St.,

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

(c) Place: burial or cremation CALVARY CEM. Brockland Ind. Co

18. (a) Signature of funeral director J. F. Breuch

(b) Address 1827 Hogan Str.

19. (a) NOV 16 1944 (Date received local registrar) J. F. Breuch (Registrar's signature)

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

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.....

W Wilkinon

Licensed Embalmer No.....

3570

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.