

FILED DEC 27 1944
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10535

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

1. 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:
3868a Shenadoah
(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 RAM

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17

(d) Street No. 3868a Shenadoah
(If rural, give location) 317

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Amanda Garrison

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

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

7. Birth date of deceased March 9 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 8th, year 1944 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec. 7, 1944, to Dec. 8, 1944 that I last saw her alive on Dec. 8, 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months 8 Days 29 If less than one day _____ hr. _____ min.

Immediate cause of death chronic myocarditis Duration 1 yr

Due to _____

Due to 93

9. Birthplace Calhoun County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

Other conditions Hypertension, cardiac asthma, arteriosclerosis (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name Winterton Cox

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

14. Maiden name Sophia Harrell

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

16. (a) Informant Rose Mueller

(b) Address 3909 Lafayette

17. (a) Burial (b) Date thereof 12-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

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? _____

18. (a) Signature of funeral director Wm. Stuart

(b) Address 1225 Union Blvd

19. (a) DEC 11 1944 (Date received local registrar) J. F. Budeck (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Walter Abel (M. D. or other) M.D.

Address 2253 No 39th Date signed 12-9-44

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 Agninski

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.