

Registration District No. _____

Primary Registration District No. **1003**

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:
Park Lane Memorial
(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

3. (a) PRINT FULL NAME **Ethel Hansen**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **at home**

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

6. (b) Name of husband or wife **Emil Hansen** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **August 14, 1901**
(Month) (Day) (Year)

8. AGE: Years **43** Months **4** Days **26** If less than one day 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 **Thomas Scargtough**

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

14. Maiden name **Don't know**

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

16. (a) Informant **Emil Hansen**

(b) Address **3949 Olive St.**

17. (a) **Burial** (b) Date thereof **Jan. 13, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Concordia Cemetery Weick Bros.**

18. (a) Signature of funeral director _____
(b) Address **2201 S. Grand Bl.**

19. (a) **JAN 12 1945** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wash**
(c) City or town **St. Louis** **19 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3949 Olive St.** **19**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **10**
year **1945** hour **8** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **Jan 10 1945** to **Jan 10 1945**
that I last saw him alive on **Jan 10 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Uterus**

Due to _____

Due to _____

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

Major findings: 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) _____ (e) Means of injury _____

23. Signature **Alyce E. Kane** (M. D. or other) **MD**

Address **706 Walton** Date signed **1-11-45**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Dany G. Stewart

Licensed Embalmer No.....3722.....

P. O. Address.....412 Duchouquette St.....

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.