

FILED FEB 7 1945  
318

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

Primary Registration District 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 Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days)  
 In this community 13 years

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. 3623a Aldine Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Hazel Largent

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

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

6. (b) Name of husband or wife Floyd Largent 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased May 24, 1916  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	28	8	2	_____ hr. _____ min.

9. Birthplace Charleston, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Robert Traylor

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

14. Maiden name Arlena Franklin

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

16. (a) Informant Mr. Floyd Jack Largent

(b) Address 3623a Aldine Ave.

17. (a) Removal (b) Date thereof Jan 28th, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Missouri

18. (a) Signature of funeral director Calvin P. Peutz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) JAN 27 1945 (b) J. Z. Bredus  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 26th  
 year 1945 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from Jan 21 to Jan 26, 1945  
 that I last saw her alive on Jan 26, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease

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

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

Other conditions 95  
(Include pregnancy within 3 months of death)

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

Of autopsy Same

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 James J. Smith (M. D. or other) \_\_\_\_\_  
 Address 1518 Lafayette Date signed 1/27/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 A. Mlesian*

Licensed Embalmer No. *4186*

P. O. Address. *St. Louis Mo*

**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.**