

1 X35897

Registration District No. **194318**

Primary Registration District No. **1003**

Registrar's No. **29**

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

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: **St. Johns 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 _____
years, months or days

3. (a) PRINT FULL NAME **Cecila Mercurio.**

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 **Married**

6. (b) Name of husband or wife **Peter Mercurio.**

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

7. Birth date of deceased **Aug. 16, 1888**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	4	15	hr. _____ min.

9. Birthplace **St. Louis, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework.**

11. Industry or business _____

12. Name **Kasper Stroehle**

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

14. Maiden name **Kathryn Goetz.**

15. Birthplace **New York, N. Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Peter Mercurio**

(b) Address **9661 Olive St. Road.**

17. (a) **Burial**
(Burial, cremation, or removal)

(b) Date thereof **Jan. 4, 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **James H. Weber**

(b) Address **1431 Union Bldg.**

19. (a) **JAN 5 1945**
(Date received local registrar)

J. F. Bredech
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.**

(b) County **Olivette Village.**

(c) City or town **St. Louis**

(d) Street No. **9661 Olive Street Road.**
(If outside city or town limits, write "RURAL") (If rural, give location)

(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **1st**
year **1945** hour **10** minute **25 P.**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 **Fracture of skull base of brain with shuffell down the depression just prior to fracture of base of brain in Green Cove Mo. Jan 1st 1945 about 8 PM**

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) **Accident**

(b) Date of occurrence **Jan 1, 1945**

(c) Where did injury occur? **Green Cove Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home on farm, in industrial place, in public place? **Home**

While at work? **no** (Specify type of place)

(e) Means of injury **fall**

23. Signature of embalmer **Patricia J. Taylor**
(Date signed) **1-3-45**

Address **1300 Clark** Date signed _____

APR 10 1934

Lechner

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 *Frank Lechner*

Licensed Embalmer No. *2915*

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.