

FILED JAN 31 1945 318

State File No. _____

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 427

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:
1917^a Pestalozzi St.
(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 St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1917^a Pestalozzi St.
(If not in the location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14th
 year 1945 hour _____ minute 10 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: 107

Due to: _____

Due to: Broncho pneumonia
Primary

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)

While at work? _____ (e) Means of injury _____

23. Signature: Edw. E. Taylor (M. D. or other) _____
 Address: 204 E. W. Date signed: 1/14/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Delila Lana Rose Nichols

8. (b) If veteran; _____ name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Sept. 12, 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name William R. Nichols

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

14. Maiden name Constance Bennett

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

16. (a) Informant Mrs. William M. Gavack

(b) Address 2421 Elliott Ave.

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

(c) Place: burial or cremation Portageville Mo.

18. (a) Signature of funeral director Chas. A. Bull

(b) Address 4452 Washington Blvd.

19. (a) JAN 16 1945 (b) J. F. Breder
(Date received local health authority) (Registrar's signature)

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

2
0-39
-39
21492

2120

2120

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 Ketter*

Licensed Embalmer No. 3880

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, above space should be left blank.