

FILED JAN 31 1945
Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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: 5808 Maple Ave.
(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 _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5808 Maple Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mayme M. Powers

3. (b) If veteran, name war _____ 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 William J. Powers 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased March 26 1889
(Month) (Day) (Year)

8. AGE: Years 55 Months 9 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name John Dunne

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

14. Maiden name Margaret Breslin

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

16. (a) Informant William J. Powers

(b) Address 5808 Maple Ave.

17. (a) Burial (b) Date thereof 1/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Street-Carroll

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Ave.

19. (a) JAN 16 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13
year 1945 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from Mar 4, 1944 to Jan 13, 1945
that I last saw her alive on Jan 13, 1945
and that death occurred on the day and hour stated above.

Immediate cause of death Valvular heart disease

Due to 92

Other conditions Hypertension
(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:

(c) 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address 3720 Washington Date signed 1/16/45

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..... *Sheldon Collier*

Licensed Embalmer No. *3382*

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.