

FILED FEB 13 1945

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2794

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Wellston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
6434 Wellsmar Avenue.  
(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 Wellston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6434 Wellsmar Avenue.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ida E. Treadway.

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 Divorced  
6. (b) Name of husband or wife Dallas Treadway.  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased January 12, 1877.  
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 2  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

MOTHER FATHER  
12. Name Jasper Orrich.  
13. Birthplace Missouri.  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Edmonds.  
15. Birthplace Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Hazel Treadway.  
(b) Address 6434 Wellsmar Avenue.

17. (a) Burial (b) Date thereof 1-16-1945.  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ironton, Missouri.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.  
(b) Address 5966-68 Easton Avenue.

19. (a) 1/16/45 (b) E. G. Malvaran, M.D.  
(Date received local registrar) (Registrar's signature) Address 1506 N. Diamond Date signed 1/15/45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th.  
year 1945 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from Apr. 4 - 4-4  
1945 to Jan 14, 1945  
that I last saw her alive on Jan 12, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death acute congestive heart failure  
mitral regurgitation  
over a period of years.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 926

Duration

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) \_\_\_\_\_  
(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 0  
Signature H. D. Hawker M.D. (M. D. or other)  
Address 1506 N. Diamond Date signed 1/15/45

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: *Ben C. Hoffman*  
Licensed Embalmer No. *4266*  
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.