

Registration District No. 318 Primary Registration District No. 1005

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
(Specify whether  
 In this community 30 yrs  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County \_\_\_\_\_  
 (c) City or town St Louis  
(If outside city or town limits, write "RURAL.")  
 (d) Street No. 2307a Delmar  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Neely Ledbetter  
 (b) If veteran \_\_\_\_\_ (c) Social Security name war \_\_\_\_\_ No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month January day 31  
 year 1945 hour 2 minute 45 am

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Unknown  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 25, 1945 to January 31, 1945;  
 that I last saw her alive on January 31, 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
 Duration 3 wks.

8. AGE: 71 Years Unknown Months Unknown Days Unknown hr. \_\_\_\_\_ min. \_\_\_\_\_  
If less than one day

Due to \_\_\_\_\_  
 Due to 107

9. Birthplace Ky. 1  
(City, town, or county) (State or foreign country)  
 10. Usual occupation nil

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

11. Industry or business \_\_\_\_\_  
 12. Name Unknown  
 13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Aretta Salney  
 (b) Address 2313 Delmar  
 17. (a) Burial (b) Date thereof Feb 6/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Greenwood Cem  
 18. (a) Signature of funeral director F. C. Green  
 (b) Address 2915 Franklin Ave  
 19. (a) FEB 5 1945 (b) J. F. Bredes  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature B. T. Murphy (M. D. or other) \_\_\_\_\_  
 Address 2601 N. Whittier St Date signed 2-45

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.....

*G. O. Sheen*

Licensed Embalmer No.....

*2963*

P. O. Address.....

*2915 Franklin ave*

**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.**