

FILED FEB 24 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 9044 Camellia
(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 ST. LOUIS MO (b) County OWN 1710
(c) City or town ST. LOUIS 9
(If outside city or town limits, write "RURAL")
(d) Street No. 4044 Camellia
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ADA LOWRY

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife AITON 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased April 20 1886
(Month) (Day) (Year)

8. AGE: Years 58 Months 9 Days 20 If less than one day hr. _____ min. _____

9. Birthplace ST. LOUIS MO (City, town, or county) (State or foreign country) 0

10. Usual occupation House wife

11. Industry or business SBIB

MOTHER FATHER { 12. Name WILLIAM POOLE
13. Birthplace ENGLAND (City, town, or county) (State or foreign country) 4
14. Maiden name DONT KNOW
15. Birthplace DONT KNOW (City, town, or county) (State or foreign country) 9

16. (a) Informant AITON Lowry
(b) Address 6044 CAMMILLA

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 1945
(Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director David Under
(b) Address 3710 9th Grand Blvd.

19. (a) FEB 14 (b) J. F. Bedick
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 10th
year 1945 hour 6 minute 30A.M.

21. I hereby certify that I attended the deceased from 2/7 1945 to 2/10 1945
that I last saw him alive on 2/10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 days

Due to Hypertension

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations _____

Of autopsy none

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) none

(b) Date of occurrence none

(c) Where did injury occur? none
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work? none (Specify type of place) (Means of injury)

23. Signature Prentice C. Hall (M. D. or _____)

Address 3902 Lafayette Date signed 2/13/45

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

E17. Princeton R Hall
3912 2nd St
Grand St 74
Mar 60 80
11-12
236-14

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 A. Moore*

Licensed Embalmer No..... *3041*

P. O. Address..... *2117 E Grand*

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.