

FILED APR 13 1945

Registration District No. **318** Primary Registration District No. **1003**

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

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:
5600 a South Compton ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **A nnie Desmond**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **None**

4. Sex **Female** **5. Color or race** **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Da n Desmond**

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

7. Birth date of deceased **October 22-1881**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	86	5	11	_____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Peter Delarber**

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

14. Maiden name **Barbara Schwartz**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Josie Desmond**

(b) Address **5600 A S. Compton ave.**

17. (a) Burial, cremation, or removal **Burial** **(b) Date thereof** **April 5, 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive Cem.**

18. (a) Signature of funeral director **C. Hoffmeister U. & L. C. O.**
(b) Address **781 S. Broadway**

19. (a) APR 4 1945 **(b) J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **060**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5600 S. Compton ave.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **3** year **1945** hour **2** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **4/3** **1945** **3/1/31**
4/3 **1945** **4-3-** **1945**
that I last saw h. **or** alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis.**
93

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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)

Signature **Albert Priest** **(M. D.)**
Address **3109 S. Main** **Date signed** **2/3/45**

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 Harry J. Schinacher

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

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.