

Registration District No. **818**

Primary Registration District No. **1003**

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: City Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 years
In this community 6 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME NANCY FORDE

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

4. Sex Female 5. Color or race Colored 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 3 6 1860
(Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 27 If less than one day hr. _____ min.

9. Birthplace Hamburg Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER
12. Name Nelson Hayes
13. Birthplace Ark
(City, town, or county) (State or foreign country)
14. Maiden name Narcissa Bowens
15. Birthplace Ark
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Windshelmer
(b) Address 5800 Arsenal St

17. (a) Burial (b) Date thereof 3-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Regent Wilson

(b) Address 2624-31 Cole Street

19. (a) MAR 5 1945
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd; 1945
year 1945 hour 4:45 minute A.M. M.

21. I hereby certify that I attended the deceased from November 2nd, 1942, to March 3rd, 1945; that I last saw her alive on March 3rd, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative heart disease Duration _____

Due to _____
Due to _____

Other conditions Senility
(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:

(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 _____

23. Signature Dr. Maxwell (M. D. or other) _____
Address 5800 Arsenal Date signed 3-3-45

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.