

**JUN 3 1945** **318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

Registrar's No. **5449**

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: Missouri Baptist Hospital  
(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)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Flat River **94**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Eunice Hovis

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife G.C. Hovis

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

7. Birth date of deceased: October 17 1876  
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 5  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name John B. Deblois

13. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Swope

15. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant G.C. Hovis

(b) Address Flat River, Mo.

17. (a) Burial (b) Date thereof 6-24-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 22 1945 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21  
year 1945 hour 4:35 minute A. M.

21. I hereby certify that I attended the deceased from March 15 1944 to June 21 1945;  
that I last saw her alive on June 20 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis  
vascular hypertension

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

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

Duration 4 mo.  
years

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Raymond Wilburn (M. D. or other) \_\_\_\_\_  
Address 114 N. Taylor, St. Louis, Mo. Date signed 6/22/45

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

10  
7  
9

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 *D. W. Wilkinon*

Licensed Embalmer No. *3575*

P. O. Address.....

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.