

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED 31821 1945

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 8012

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:
3510 N. Taylor Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ ? _____ (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 00. 10

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

(d) Street No. 3510 N. Taylor Ave. 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Hattie S. Helms

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 Andrew J. Helms

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

7. Birth date of deceased February 2, 1866
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12th
year 1945 hour 5:55 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 12 to Sept 12, 1945, that I last saw her alive on Sept 11, 1945, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>7</u>	<u>10</u>	_____ hr. _____ min.

Immediate cause of death Cerebral hemorrhage

Due to age - arterio-sclerosis

Due to _____

9. Birthplace Rensselaer, Missouri
(City, town, or county) (State or foreign country)

Other conditions Paraplegia (Right)
(Include pregnancy within 3 months of death)

10. Usual occupation Housework

11. Industry or business _____

12. Name E. Briggs

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

14. Maiden name Dee Horton

15. Birthplace New York 1
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations: 8301

Of autopsy: _____

16. (a) Informant Mrs. Hazel McMahan

(b) Address 3510 N. Taylor Ave.

17. (a) Removal (b) Date thereof Sept. 15, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield, Missouri

18. (a) Signature of funeral director Calvin F. Feutz: Funeral

(b) Address 4828 Natural Bridge Bldg.

19. (a) SEP 13 1945 (b) J. B. Brudek
(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? _____

Home _____ (Specify type of place)

While at work? _____ Means of injury _____

23. Signature J. B. Brudek (M. D. or other) M.D.

Address 705 - Olive St. St. Louis Date signed 9/13/45

Mr. S. M. Houghton 2-4

John A. Minner
St. Louis, Mo.

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 *John A. Minner*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis Mo*

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.