

FILED OCT 13 1945

Registration District No. 379

Primary Registration District No. 3063

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

1. PLACE OF DEATH:
 (a) County ST. LOUIS
 (b) City or town CLAYTON
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
53 CRESTWOOD DRIVE
 (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 PATRICIA ANN VARNER
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race W
 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased JUNE 11 1922
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>3</u>	<u>27</u>	hr. min.

9. Birthplace MO (City, town, or county) (State or foreign country)
 10. Usual occupation AT HOME

MOTHER FATHER

11. Industry or business _____
 12. Name LEOR VARNER
 13. Birthplace IOWA (City, town, or county) (State or foreign country)
 14. Maiden name LORETTA CONDON
 15. Birthplace IOWA (City, town, or county) (State or foreign country)

16. (a) Informant W. J. Muller
 (b) Address #53 Crestwood Drive
 17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 10 - 1945
 (Month) (Day) (Year)
 (c) Place: burial or cremation CALVARY CEMETARY

18. (a) Signature of funeral director W. J. Muller
 (b) Address 516 S. Delmar Bl.
 19. (a) 10-10-45 (Date received local registrar) (b) W. J. Muller (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County ST. LOUIS
 (c) City or town CLAYTON (If outside city or town limits, write "RURAL")
 (d) Street No. 53 CRESTWOOD DRIVE (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8 year 1945 hour 7:30 minute _____ M.
 21. I hereby certify that I attended the deceased from 10-5- _____, 1945 to 10-7- _____, 1945
 that I last saw her alive on 10-7-45 11:30 am and that death occurred on the date and hour stated above.

Immediate cause of death Edema of Glottis Duration _____
 Due to Streptococcus throat
 Due to 11/13
 Other conditions no (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) (e) Means of injury _____
 23. Signature J. P. Kennedy (M. D. or other) _____
 Address 634 N. Grand Date signed 10-8-45

FEB 18 1946

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 *A. G. Jones*.....

Licensed Embalmer No. *3384*.....

P. O. Address *A. Jones*.....

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.