

FILED OCT 25 1945  
Registration District No. 318

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 8935

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: Enroute City Hospital 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None (Specify whether)  
In this community 15 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1417 South 7 th, St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Etta Creswell

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Septon 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 13 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 0 1 hr. \_\_\_\_\_ min.

9. Birthplace Batesville Ark  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

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

12. Name Abner Nixox

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

14. Maiden name Unknown

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

16. (a) Informant Hayden Barnes

(b) Address 1456 Waeren

17. (a) Burial (b) Date thereof Oct. 17 /45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) OCT 16 1945 (b) J. F. Predest  
(Date received from Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14 year 45 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Gronny Thompson

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

Due to 94

Other conditions \_\_\_\_\_  
(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?

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature of physician Patrick E. Taylor, Dep. Cor  
Address 1300 Clark Date signed 10-16-45

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

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17  
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**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 L.R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

**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.**