

7. S. No. 2
ROOM-5-43
Rev. 5-17-39
I X36871

FILED NOV 3 1945
Registration District No. 217

Primary Registration District No. 6076

State File No. 34630
Registrar's No. 2472

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Miller Nursing Home 4
(If not in hospital or institution, write street number or location)

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

In this community _____ years, months or days

3. (a) PRINT FULL NAME Emma Jaekel

3. (b) If veteran, name war 720

3. (c) Social Security No. 720

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Oct 9 1884
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 11

If less than one day _____ hr. _____ min.

9. Birthplace Boston _____
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Unknown Smith

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

14. Maiden name "

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

16. (a) Informant Martin Lubbes

(b) Address 8700 Gravois Av.

17. (a) Burial (b) Date thereof 10-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter + Paul Cem.

18. (a) Signature of funeral director With Bur. & No.

(b) Address 2929 S. Jefferson Av.

19. (a) 10-27-45 (b) W. M. Gorman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 1019 Paul St. _____
(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 20
year 1945 hour 9 minute 30p. M.

21. I hereby certify that I attended the deceased from Aug 28
_____ 1945 to Nov 17 1945
that I last saw her alive on Nov 17 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of left side _____
Duration _____

Due to Atrio-sclerosis _____

Due to _____

Other conditions Diabetes _____
(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 W. M. Gorman (M. D. or other) MD
Address 1209 N. Kings Highway Date signed 10-27-45

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.....

Licensed Embalmer No.....

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.