

FILED NOV 19 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St/ Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2762 Bacon St.
(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 Rosie E. Ennis
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 Married
6. (b) Name of husband or wife Troy Ennis 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased November 9, 1894
(Month) (Day) (Year)

8. AGE: Years 51 Months 0 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace St. Francis, Ark.
(City, town, or county) (State or foreign country)
10. Usual occupation Housework

MOTHER FATHER

11. Industry or business _____
12. Name John Wesley
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Olds
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Troy Ennis
(b) Address 2762 Bacon St.
17. (a) Burial (b) Date thereof Nov. 14, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Campbell, Missouri

18. (a) Signature of funeral director Paschedag-Henke Fun Home
(b) Address 2825 N. Grand Blvd.
19. (a) NOV 11 1945 (b) J. F. Breda
(Date received for registration) (Registrar's signature)

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. 2762 Bacon St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 10
year 1945 hour 3 minute 40P M.
21. I hereby certify that I attended the deceased from Apr 4 1945
1945 to Nov 10 1945
that I last saw her alive on 11-10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

Duration _____
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? _____
23. Signature Chas E Kane MD (M. D. or other)
Address 1706 Walnut Date signed 11-10-45
Home _____ (Specify type of place) (c) Means of injury _____

KANE

MAR 4 1959

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.....

J. W. Wilkins

Licensed Embalmer No.

3578

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.