

Registration District No. 318

Primary Registration District No. 1003

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:
1409a Dolman
(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) 11 Years
In this community _____

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. 1409a Dolman
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SARAH HESTER CHRISTENSEN

3. (b) If veteran, name war _____ 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 _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 16 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Levy Richardson

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

14. Maiden name Emma Jane Dickerson

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

16. (a) Informant Mrs Edith Cowley

(b) Address 1409a Dolman

17. (a) Removal (b) Date thereof 12-29-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford, Mo.

18. (a) Signature of funeral director McBoughlin Funeral Home

(b) Address 2301 Lafayette

19. (a) DEC 25 1945 (b) J. F. Breder
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27th
year 1945 hour 3 minute 30 A M.

21. I hereby certify that I attended the deceased from Jan 22 1945 to Dec 27 1945
that I last saw her alive on Dec 26 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardiac
Heart Disease Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. Buchanan (M. D. or other) _____

Address 2355 Lafayette Date signed 12-28-45

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

MOTHER FATHER

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 O. W. Cooper
Licensed Embalmer No. 3830
P. O. Address 2301 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.