

FILED DEC 21 1945
 318

State File No. _____
 Registrar's No. **10824**

Registration District No. _____ 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:
5333 Arlington Ave. 1
 (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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5333 Arlington Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? **1** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Lydia Mott**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **11**
 year **1945** hour **6** minute **30** A. M.
21. I hereby certify that I attended the deceased from **Dec 11**
 19 **45** to **Dec 11** 19 **45**
 that I last saw her alive on **Dec 10** 19 **45**
 and that death occurred on the date and hour stated above.

4. Sex **female** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced, divorced
6. (b) Name of husband or wife **Charles H. Mott**
6. (c) Age of husband or wife if _____
 alive _____ years
7. Birth date of deceased **Jan. 17 1853**
 (Month) (Day) (Year)

Immediate cause of death **apoplexy**
 Due to **chronic arterio sclerosis**
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	92	10	24	_____ hr. _____ min.

Major findings: _____
 Of operations _____
 Of autopsy _____

9. Birthplace **Dayton Va 1**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Benjamin Bowman**
13. Birthplace **Unknown 9**
 (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown 4**
 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **Mrs. Chas. Behrend 2**
(b) Address **5333 Arlington Ave.**
17. (a) Burial **(b) Date thereof** **12-13-45**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park**

23. Signature **R. R. Harrison** (M. D. or other) **11/12**
Address **5330 General** **Date signed** **12/12/45**
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

18. (a) Signature of funeral director **Drehmann-Harral**
(b) Address **1905 Union Blvd.**
19. (a) DEC 12 1945 (b) **[Signature]**
 (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration **10 days**
Double
Funeral
PHYSICIAN
 Underline the cause to which death should be charged statistically.

244

5330 Renewal License

11 to 1 Street Nurses.

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..... *Albert R. Thompson*.....

Licensed Embalmer No. *4287*.....

P. O. Address..... *St Louis*.....

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.