

FILED JUN 21 1946

Registration District No. 277

Primary Registration District No. 6076

Registrar's No. 66

1. PLACE OF DEATH:

(a) County St. Louis Co.
(b) City or town W. Walnut Manor
(c) Name of hospital or institution 5338 Jennings Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 yrs.
In this community years, months or days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town W. Walnut Manor
(d) Street No. 5338 Jennings Rd.
(e) Citizen of foreign country? No.
If yes, name country _____

3. (a) PRINT FULL NAME Frank Michael Creamer

3. (b) If veteran, name, war _____ 3. (c) Social Security No. 492-03-8247

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Bessie A 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 12 - 1880
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Boilermaker

11. Industry or business Unemployed

12. Name Frank Creamer

13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Sanders

15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Marie Malone

(b) Address 5338 Jennings Rd.

17. (a) Burial (b) Date thereof 1/10/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Harry A. Sheehan

(b) Address 4415 Washington Blvd

19. (a) 6607 (b) Wm. J. ...
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 7
year 1946 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from Dec 5, 1945 to Jan 7, 1946
that I last saw him alive on Jan 7, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis (left)

Due to arteriosclerosis

Due to hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Wm. J. ... (M. D. or other) _____
Address 6607 ... Date signed 1-7-46

Duration

1 year 4 months

3

80

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2089

MAR 18 1945

JAN 25 1945

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed *Albert G. Hoffe*

Licensed Embalmer No. *2991*

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.