

DEPARTMENT OF COMMERCE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED MAR 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. **11380**

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **2308**

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: St. Anthony Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 1 day
(Specify whether)

In this community _____
years, months or days

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. 550 Eiler St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rose Lockett

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Forrest E.

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased July 24 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>7</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Forrest E. Lockett

(b) Address 550 Eiler St.

17. (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park

18. (a) Signature of funeral director Wanda Hildale

(b) Address 3634 Gravois Ave.

19. (a) J. F. Brueck
(Date received) (Local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 7
year 1946 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-4 1946 to 3-7 1946
that I last saw her alive on 3-7 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Embolism Duration 5 min.

Due to Post operative Cholecystectomy

Due to _____

Other conditions men 127
(Include pregnancy within 3 months of death)

Major findings: Ruptured gallbladder
Of operations a gangrenous situation

Of autopsy none

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 0

23. Signature A. J. Shelton (M. D. or other) MD
Address 3608 S. Grand Date signed 3-8-46

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

100000

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.....

Frank J. Gland

Licensed Embalmer No.....

2675

P. O. Address.....

St. Louis, Mo

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.