

FILED MAY 31 1946 STANDARD CERTIFICATE OF DEATH

State File No. ....

318

1003

4596

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
Name of hospital or institution Park Lane Memorial Hospital  
(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 County St. Louis  
(c) City or town St. Louis  
(d) Street No. 4532 San Francisco  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1946 hour 10 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from May 1, 1946 to May 20, 1946  
that I last saw her alive on May 20 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
Permanent coronary following  
removal of the right breast and  
Due to coronary glaucoma  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 Clarence L. Holts (M. D. or other) \_\_\_\_\_  
Address 409 Chemical Bldg Date signed 5/21/46

3. (a) PRINT FULL NAME Nellis Egbert  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security 496-18-7797  
4. Sex Female 5. Color Wh 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 9 1896  
(Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Lincoln City Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Sales Lady

11. Industry or business Gump - Barr

12. Name Ernst Egbert

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

14. Maiden name Emma Niehaus

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

16. (a) Informant Gilbert Egbert

(b) Address Postage de Sioux Mo

17. (a) Funeral (b) Date thereof May 22 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waharria

18. (a) Signature of funeral director Chas F Stewart

(b) Address 1225 Union Blvd

19. (a) MAY 22 1946 (b) J. F. Bredak  
(Date received local registrar) (Registrar's signature)

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

17240

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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.....

*W. W. Wilkerson*

Licensed Embalmer No. 3575

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.**