

FILED *318*
Registration District No. *318*

STANDARD CERTIFICATE OF DEATH

State File No. **21992**
Registrar's No. **57341**

Primary Registration District No. **1003**

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

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:
Park Lane Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days.**
(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. **5715 McPherson Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Etta Madden**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **28th.**
year **1946** hour **2:45 A.M.** minute _____ M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed.**
6. (b) Name of husband or wife **James F.**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 8th. 1864**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 2, 1941,** 19 _____ to **June 28, 1946,** 19 _____;
that I last saw her alive on **June 27, 1946**, 19 _____;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	81	6	20	hr. _____ min. _____

Immediate cause of death **Uremia,**
24 hours.

9. Birthplace _____
(City, town, or county) **Tenn.**
(State or foreign country)

Due to **Chronic interstitial nephritis, with hypertension and myocarditis.** **5 years**

10. Usual occupation **Housewife**

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

11. Industry or business **At Home**

Major findings:
Of operations _____
Of autopsy _____

12. Name **Robert Nichelson**

PHYSICIAN
Underline the cause to which death should be charged statistically.

13. Birthplace _____
(City, town, or county) **England** **4**
(State or foreign country)

14. Maiden name **Mary Walker**

15. Birthplace _____
(City, town, or county) **Va.**
(State or foreign country)

16. (a) Informant **Thomas R Madden**
(b) Address **5715 McPherson Ave.**

17. (a) **Burial** (b) Date thereof **7/1/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemt**

18. (a) Signature of funeral director **Harrigan & Sheehan Und Co**
(b) Address **4415 Washington Blvd.**

19. (a) **JUN 28 1946** (b) **J.F. Bredack**
(Date received local registrar) (Registrar's signature)

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 **J.F. Bredack** (M. D. or other) _____
Address **320 Metropolitan Bldg.** Date signed **6/28/46**

*W. S. V. [unclear]
[unclear] [unclear]*

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, *Elmer R. Sadwell*
Licensed Embalmer No. *4077*

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.