

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5301**

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Decker - 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
 (Specify whether  
 In this community 10 yr.  
 years, months or days)

3. (a) PRINT FULL NAME Pauline Maylor Prouty

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced M /  
 6. (b) Name of husband or wife Clarence J. Prouty 6. (c) Age of husband or wife if alive 40 years  
 7. Birth date of deceased 9 4 1910  
 (Month) (Day) (Year)

8. AGE: - Years 35 Months 9 Days 10 If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Duquoin Ill  
 (City, town, or county) (State or foreign country)

MOTHER, FATHER

10. Usual occupation Field Worker

11. Industry or business \_\_\_\_\_

12. Name E. E. Maylor  
 13. Birthplace Hooper Ill  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Emagie Smith  
 15. Birthplace Bond W. Ill  
 (City, town, or county) (State or foreign country)

16. (a) Informant Clarence J. Prouty  
 (b) Address 749 Westwood Drive, Clayton, Mo

17. (a) removal (b) Date thereof 6-17-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus, Ohio

18. (a) Signature of funeral director C. R. Lupton & Sons  
 (b) Address 7233 Delmar Blvd., St. Louis, Mo

19. (a) JUN 18 1946 (b) J. Prouty  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 96  
 (c) City or town St. Louis Clayton 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 749 Westwood  
 (If rural, give location) NR3  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 14<sup>th</sup>  
 year 1946 hour 9 minute 15 A.M.  
 21. I hereby certify that I attended the deceased from JUNE 8<sup>th</sup>  
1946 to JUNE 14<sup>th</sup> 1946  
 that I last saw her alive on JUNE 14<sup>th</sup> 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Partial cirrhosis  
 Due to: Chronic alcoholism

Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

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 0

23. Signature George S. Mohr (M. D. or other) MD  
 Address Reidville, General Hosp Date signed 6-24-46

**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 Clarence H. Murray  
Licensed Embalmer No. 4011  
P. O. Address St. Louis, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

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:  
(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)

3. (a) PRINT FULL NAME Pauline M. Proenty  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
7. Birth date of deceased Sept (Month) 1914 (Year)

8. AGE: Years 35 Months 9 Days 10 If less than one day hr. min.

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

10. Usual occupation Green Berker

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. R. Brudick (Registrar's name)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month..... Day..... Year..... hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration.....

Due to.....

Due to.....

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?.....

(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

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

**SUPPLEMENTARY**

JUL 12 1940

WRITE PLAINLY—USE UNFADING INK—WRITE IN PERMANENT RECORD

880

22105