

FILED JUN 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4983

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C Starkloff Memorial
(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 Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5076 Enright
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ELIZABETH SLONE

3. (b) If veteran, name war _____ 3. (c) Social Security No. NO

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: August 16 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 16
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant M.B. Proffer
(b) Address 5076 Enright

17. (a) burial Removal (b) Date thereof 6-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Louisville, Kentucky

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Ave.

19. (a) JUN 20 1946 (b) [Signature]
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd
year 1946 hour 10:35 minute P M.

21. I hereby certify that I attended the deceased from 2/20/46
_____ 19____ to 6/2/46 19____
that I last saw her alive on 6/2/46 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Squamous cell carcinoma of buccal mucosa Duration 48

Due to _____
Due to _____

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

Major findings:
Of operations not performed
Of autopsy not obtained
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)
(c) Means of injury _____

23. Signature [Signature] 1515 Lafayette 6/3/46 (or other)
Address _____ Date signed _____

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

21083

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..... *O. W. Cooper*

Licensed Embalmer No..... *3830*

P. O. Address..... *2301 Lafayette*

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.