

FILED 318
JUL 22 1946

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. **6063**

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 _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Mary Margaret Deane**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 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 **February 16 1939**
(Month) (Day) (Year)

8. AGE: Years **7** Months **4** Days **28** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Child**

MOTHER FATHER

11. Industry or business _____
12. Name **Alfred Franklin Deane**

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

14. Maiden name **Augusta Franklin**

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

16. (a) Informant **Ralph W. Deane**
(b) Address **715 Hickory St.**

17. (a) **Burial** (b) Date thereof **7-10-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sikeston, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **JUL 9 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

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. **715 Hickory St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**
year **1946** hour **1:30 PM** minute _____ M.

21. I hereby certify that I attended the deceased from **7/7-46**
11 AM to **7/8-46**
that I last saw her alive on **7/8-46 (11 PM)**
and that death occurred on the date and hour stated above.

Immediate cause of death **abdominal perforation**
Due to _____

Due to **12/11**
Other conditions **Gaugreen appendicitis**
(Include pregnancy within 3 months of death)

Major findings: **7/8-46 1 P.M. blood @ aut**
Gaugreen appendicitis 28 weeks
Of autopsy **28 weeks**

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) **none**
(b) Date of occurrence _____
(c) Where did injury occur? **none**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
none
(Specify type of place)
While at work? _____ (e) Means of injury **none**
23. Signature **M. F. Hannan** (M. D. or other) _____
Address **2739 N. River St.** Date signed **7-8-46**

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

24093

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.