

No. 2
-12-45
5-17-39
P 1 X47070

FILED SEP 30 1946

Registration District No. 27

Primary Registration District No. 2002

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Christian Old Peoples Home 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 months
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town University City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6600 Washington Avenue 5
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Ellen O. Trager

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased November 25, 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15, 1946
year 7 hour 20 minute P M.

21. I hereby certify that I attended the deceased from Sept. 15 to Sept. 15, 1946
that I last saw her alive on Sept. 15, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

75 9 20 hr. min.

Immediate cause of death Ante Dilator of heart Duration 3 hrs.

Due to Bronchial Asthma 9

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

10. Usual occupation Retired

Other conditions 1-2
(Include pregnancy within 3 months of death)

Due to _____

MOTHER FATHER

11. Industry or business _____

12. Name Joseph A. Jennings

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

14. Maiden name Julia Ann Reaves

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

Major findings: Of operations _____

Of autopsy _____

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

16. (a) Informant Miss. Julia May Lord

(b) Address 6600 Washington Avenue

17. (a) Burial (b) Date thereof Sept 16, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Casper, Wyoming

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Avenue.

19. (a) 9-17-46 (b) Paula Schellenberg
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature A. P. Ryan (M. D. or other) _____

Address 607 N. Grand Date signed 9.16.46

OCT 17 1942

Dr. Gygans
Pa 4188

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 Ray W Wilkinson

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.