

No. 2
2-45
17-39
K47070

FILED NOV 12 1946
318

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:
(a) County
(b) City or town ST. LOUIS, MO.
(c) Name of hospital or institution: CITY INFIRMARY
(d) Length of stay: In hospital or institution 4/2/46 to 10/26/46
In this community years, months or days

3. (a) PRINT FULL NAME ELIZABETH SEPTEMBER
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex FEMALE 5. Color or Race Colored
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 (Month) (Day) (Year)

AGE: 73 Years Months Days If less than one day hr. min.

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

10. Usual occupation nil

11. Industry or business

12. Name Henry September

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

14. Maiden name Elizabeth ?

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

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal St.

17. (a) Place: burial or cremation Anatomical Board
(b) Date thereof 10-30-46 (Month) (Day) (Year)

18. (a) Signature of funeral director W. Ricketts
(b) Address 3500 Ricketts St.

19. (a) NOV 1 1946 (Date received local registrar)
(b) J. F. Brudbeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 22
(c) City or town St. Louis
(d) Street No. 20 S. 22nd St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 26 year 1946 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from April 2, 1946 to Oct. 26, 1946 that I last saw her alive on Oct. 26, 1946 and that death occurred on the date and hour specified.

Immediate cause of death Terminal Pneumonia Hypertensive Cardiovascular disease

Due to 93
Due to
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

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
23. Signature John E. Nelson, M.D. (M. D. or other)
Address 5800 Arsenal St. Date signed 10/27/46

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

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.....

Licensed Embalmer No.....

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.

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 Elizabeth September
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

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

8. AGE: Years Months Days If less than one day
ast 73hr.min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER {
 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)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

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 1946 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.....

Due to.....
 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.....
 23. Signature..... (M. D. or other).....
 Address..... Date signed.....

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

SUPPLEMENTARY

NOV 25 1946

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