

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Webster Groves
(c) Name of hospital or institution:
125 Edgar Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bernice T. Sulze
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 W. 21
6. (b) Name of husband or wife Edward Sulze 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 12th., 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 1 23 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER, FATHER {
12. Name William Murphy
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Flynn
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Florence McKinlay
(b) Address 125 Edgar Road

17. (a) Burial (b) Date thereof 12-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cathary

18. (a) Signature of funeral director Arthur J. Donnell
(b) Address 3840 Lindell Blvd.

19. (a) 12-7-46 (b) Paul J. Donnell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 125 Edgar Road
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th.,
year 1946 hour 9 minute P. M.
21. I hereby certify that I attended the deceased from Aug 7, 1946 to Dec. 5, 1946,
that I last saw him alive on Dec 3, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of transverse colon
Due to Cause unknown
Duration 1 yr +
Due to 46 yr
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of transverse colon metastasizing to liver
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 0
23. Signature R. Donnell (M. D. or other) _____
Address 117 N. Grand Date signed 12/7/46

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lindell

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.