

3. No. 2
M-5-43
7. 5-17-39
0 I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41967
Registrar's No. 3430

FILED DEC 31 1946

Registration District No. 36

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution:
6461 WELLS AVE
(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 MO (b) County ST LOUIS

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

(d) Street No. 6461 WELLS AVE.
(If rural, give location)

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

3. (a) PRINT FULL NAME FREDERICK A. CLINE

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 3rd
year 1946 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec 26, 1945, to Dec 3, 1946
that I last saw him alive on Dec 2, 1946
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased AUGUST 9th 1862
(Month) (Day) (Year)

Immediate cause of death Cerebral apoplexy

Due to Hypertension

Due to 830

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

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

84 3 24 hr. _____ min. _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically!

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

10. Usual occupation PRINTER

11. Industry or business RETIRED

12. Name F. A. CLINE

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

14. Maiden name MARY C. DAY

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

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 C. E. Sterling (M. D. or other) MO
Address 2050 North 9 South Rd Date signed 4 Dec 46

16. (a) Informant Smith Ope

(b) Address 5410 Ruston Ave

17. (a) BURIAL (b) Date thereof 12/5/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM.

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

(b) Address 516 S Delmar St

19. (a) 12-5-46 (b) Ruth Mullen
(Date received local registrar) (Registrar's signature)

St Louis # 14 MO

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

40778

8
46

OCT 16 1947

DEC 11 1946

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..... *H. G. Lewis*.....

Licensed Embalmer No. *3384*

P. O. Address..... *H. Lewis*.....

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.