

FILED JAN 16 1947

Registration District No. **16** Primary Registration District No. **8076**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution:
Torrance Nursing Home
(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 Isabelle Douglas**

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 **Unknown**

6. (c) Age of husband or wife if alive **Unk** years

7. Birth date of deceased **December 29 1858**
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
88	0	11	hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **At Home**

MOTHER FATHER

12. Name **James McAnulty**

13. Birthplace **Sparta Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Beattie**

15. Birthplace **Preston Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edna Goff**

(b) Address **Prairie DuRocher**

17. (a) **Removal** (b) Date thereof **1/11/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Renault, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **1-13-47** (b) *Auth. & Clearing*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Randolph 999**

(c) City or town **Prairie DuRocher**
(If outside city or town limits, write "RURAL")

(d) Street No. **Rural District**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **10th**
year **1947** hour **1** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **Aug 4**, 19 **47** to **Jan 10**, 19 **47**
that I last saw her alive on **Jan 3**, 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Myocardial Degeneration**

Due to **Chronic arteriosclerosis**

Due to **Chronic Hemorrhagic Encephalitis**

Other conditions (Include pregnancy within 3 months of death) **Chronic Hemorrhagic Encephalitis**

Duration
6 mo.
5 yrs.
4 yrs.

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 **A. H. Hoppe** (M. D. or other) **M.D.**

Address **1456 So. Hampton** Date signed **Jan 11-47**

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.....

J. Allen Davis Jr
.....
Licensed Embalmer No. *4053*.....

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.