

FILED APR 8 1947
318

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 3129

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: Masonic Home, 5351 Delmar Blvd.
(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 Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 12/17
(d) Street No. 5351 Delmar Blvd.
(If rural, give location) 9
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME MARY JANE LEFAVOR.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Wilton Fields Lefavor. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 27 1850
(Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day
96 2 27 hr. min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name John Harvey McMahon.
13. Birthplace Ireland (State or foreign country) 9
14. Maiden name Sue
15. Birthplace unknown (State or foreign country) 9

16. (a) Informant Mr. Nathaniel H. Lefavor.

(b) Address 4129 Shenandoah Ave.

17. (a) Burial (b) Date thereof 3-25-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) MAR 2 1947 (b) _____ (Date, Month, Day, Year) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24th
year 1947 hour 9:15 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 10,
1947, to March 24, 1947.
that I last saw her alive on March 24, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 8 mos.
Due to Senility 1 year

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? 0
While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J. F. Bremer (M. D. or other) _____
Address 508 N. Grand Boulevard Date, signed 3/24/47.

508 No. Grand
NE 7298
1 to 3 P.M.

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 Raymond L. Marr
Licensed Embalmer No. 4330
P. O. Address Maplewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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 9TH. 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 Mary Jane Sefaroc
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 wid
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased: Dec 27 1904 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
96 2 1 hr. min.

9. Birthplace: Laurens, Mo (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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bredbeck (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 Mar year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw h..... 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.....

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.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

11176

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