

FILED MAY 1 1947

Registration District No. **318**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. JOHNS
(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)

In this community **6 DAYS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILL.** (b) County **RANDOLPH.**

(c) City or town **CHESTER, ILL.**
(If outside city or town limits, write "RURAL")

(d) Street No. **NONE** **NRO**
(If rural, give location)

(e) Citizen of foreign country? **NO** **2**
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **SYLVIA M. BLOOME**

3. (b) If veteran, name war _____

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **21** year **1947** hour **11** minute **30** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **R. C. BLOOME**

6. (c) Age of husband or wife if alive **54** years

7. Birth date of deceased **JUNE 18 1891**
(Month) (Day) (Year)

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: **Almony Alcoholic 2 Cycles Organic Anoxemia while undergoing an operation April 6 found a broken leg at St. Johns Hospital on April 22 1947**

8. AGE:	Years	Months	Days	If less than one day
	55	10	3	— hr. — min.

Other conditions: _____

Major findings: **1/12**

Of autopsy: _____

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

10. Usual occupation **HOUSE WIFE**

11. Industry or business **HOUSEWIFE**

12. Name **JOHN T. GODSON**

13. Birthplace **UNKNOWN ILL.**
(City, town, or county) (State or foreign country)

14. Maiden name **IDA SISSON**

15. Birthplace **UNKNOWN ILL.**
(City, town, or county) (State or foreign country)

16. (a) Informant **R. C. Bloome**

(b) Address **CHESTER, ILL.**

17. (a) ~~BURIAL~~ **Evergreen Cemetery** (b) Date thereof **APRIL 24 1947**
(Special, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **John E. Schreder**

(b) Address **Chester, Ill.**

19. (a) **APR 22 1947** (b) **J. F. Bredenk**
(Date received local registrar) (Registrar's signature)

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 **2**

23. Signature **Patricia E. Taylor** (M. D. or other) _____
Address **Deputy Coroner** Date signed **4-22-47**

PHYSICIAN

Underline the cause to which death should be charged statistically.

PS FEB 23 1960

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 Oscar B. Schroeder

Licensed Embalmer No. 1751

P. O. Address Chester, Ill.

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.