

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3970

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(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.....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 6933 Arthur Ave
Memorial (If rural, give location)

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

3. (a) PRINT FULL NAME ROSE STINSON

3. (b) If veteran, name war none

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th
year 1947 hour 11:50 minute A M.

21. I hereby certify that I attended the deceased from 3/31/47
to April 15th, 1947
that I last saw er alive on April 15th, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nlyses S. Stinson 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased June 15 1870
(Month) (Day) (Year)

Immediate cause of death.....
Anemia

Due to Chy. pyelonephritis

Due to NON-calculous

Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
76 10 0 hr. min.

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

10. Usual occupation Housewife

PHYSICIAN

Major findings:
Of operations.....
Of autopsy AME

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name Thomas Siciliano

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

14. Maiden name Ann

15. Birthplace Ireland
(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?

23. Signature [Signature] 1515 Lafayette (M. D. or other)
Date signed 4/25/47

16. (a) Informant Kathryn C. Swift

(b) Address 6933 Arthur

17. (a) Burial (b) Date thereof Apr 18 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter + Paul

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 N. 1st St.

19. (a) APR 16 1947 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

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 3454

....., Registered Apprentice No.....
working under my personal supervision.

Signed David C Gibson

Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

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.