

Registration District No. 317

Primary Registration District No. 4467

96
16
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis Co.

(b) City or town VALLEY PARK Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mohl Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 DAYS
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Luey B. FREMONT

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 Felix

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

7. Birth date of deceased May 27 1876
(Month) (Day) (Year)

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

70 11 1 hr. _____ min.

9. Birthplace DALLAS, TEX 1
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER, FATHER

12. Name Unknown Killen 9

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

14. Maiden name Unknown 9

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

16. (a) Informant Charles W. Fremont

(b) Address 8521 Clifton

17. (a) Burial (b) Date thereof 5/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Proved and Co.

(b) Address 3710 N. Grand Blvd

19. (a) 5-2-47 (b) Becky Sharpe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town VALLEY PARK 16
(If outside city or town limits, write "RURAL")

(d) Street No. Mohl Nursing Home-604 West 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 27
year 1947 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from Apr 25 1947 to Apr 27 1947
that I last saw her alive on Apr 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Cardio renal disease 10 yrs
Cerebral Hemorrhage 4 da
RT.

Due to 131a

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. D. Seabach (M. D. or other) 27th
Address Webster Brooks Date signed 4/28/46

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.....

W. Morris

Licensed Embalmer No.....

3360

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.