

S. No. 2  
M-5-43  
5-17-39  
I X36671

FILED JUN 5 1948

Registration District No. ....

Primary Registration District No. ....

1003

Registrar's No. ....

5201

1. PLACE OF DEATH:

(a) County.....  
(b) City or town City St. Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Infirmary Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11-3-44/5-23-47  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town City St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5800 Arsenal St.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Sarah Bickford

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

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced WIDOW, 2  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased 11 11 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 6 12 hr. min.

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

10. Usual occupation Nil.

11. Industry or business.....

12. Name Alexander Stewart

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

14. Maiden name MARY Klein

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

16. (a) Informant City Inf. Re  
(b) Address 5800 Arsenal ST.

17. (a) Burial (b) Date thereof 5/26/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director Chulick Und. Co.

(b) Address 1722 S. Jefferson Ave.

19. (a) MAY 26 1948 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 23  
year 1947 hour 10 minute 50p:M.

21. I hereby certify that I attended the deceased from 11  
3 1944 to 5-23-47 1947  
that I last saw h. er alive on May 23, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia: Hypostatic  
Due to Senility 1626.

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. Shorney (M. D. or other)  
Address 5600 Arsenal Date signed 5-24-47

*raw*  
*137*  
*9*

*1110*

Duration  
11c

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

(Shorney)

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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..... *Alex A. Chulick Jr.*  
Licensed Embalmer No..... *4143*  
P. O. Address..... *1722 S. Jeff*

**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.**