

No. 2  
-12-45  
-17-39  
X47070

FILED MAY 22 1947

318

Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

4796

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:  
4119A DONOVAN PLACE  
(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 GRACE JANE ELDER.

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

4. Sex FEMALE 5. Color or race W. 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CLARENCE ELDER 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased NOVEMBER 4 1880  
(Month) (Day) (Year)

8. AGE: 66 ~~58~~ Years Months 6 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSEKEEPER

11. Industry or business OWN

12. Name JAMES BROWN

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

14. Maiden name LEE

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

16. (a) Informant Mrs. Florence Snyder.

(b) Address 4523 ARCO AV

17. (a) BURIAL (b) Date thereof MAY 13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director S. J. Schauer  
(b) Address 3125 Lafayette Av

19. (a) MAY 12 1947 (Date received local registrar) J. J. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 020  
(c) City or town ST. LOUIS 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4119A DONOVAN PLACE 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10-47  
year \_\_\_\_\_ hour 11:30 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 1946 to May 10 1947  
that I last saw him alive on May 10 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Complications of kidneys Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 52

Other conditions (include pregnancy within 3 months of death) M-E Skatman S

Major findings: Of operations \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

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) (d) Means of injury \_\_\_\_\_

23. Signature M-E Skatman (M. D. or other) 5/12/47  
Address 4300 Pinecrest Date signed \_\_\_\_\_

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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.....

*John B. Vallman*

Licensed Embalmer No. *4014*

P. O. Address *325 Lafayette Ave 4th*

**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.**