

FILED JUL 26 1947  
318

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town ST LOUIS  
(c) Name of hospital or institution: PARK LANE HOSP  
(d) Length of stay: In hospital or institution 3 DAYS  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME LUCINDA F TERRELL  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_  
4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife GEORGE 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased JUNE - 10 - 1868  
(Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation RETIRED

11. Industry or business \_\_\_\_\_  
12. Name NATHANIEL McCLAIN  
13. Birthplace TEXAS  
(City, town, or county) (State or foreign country)  
14. Maiden name EMILY JANE WILLIAMSON  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature HULDA NELSON  
(b) Address NEW HARMONY IND.

17. (a) REMOVAL (b) Date thereof 7-15-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CARMI. ILL

18. (a) Signature of funeral director ROWLAND FUNERAL SER  
(b) Address 4355 WASHINGTON AV

19. (a) 15000 90 23 (b) J. F. Break  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State ILL (b) County WHITE  
(c) City or town ENEFIELD  
(d) Street No. NR.  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JULY day 12<sup>th</sup> year 1947 hour 6 minute 30 A. M.  
21. I hereby certify that I attended the deceased from June 1st, 1947, to July 12th, 1947  
that I last saw her alive on July 11th, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
Due to \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature Clara E. Kline (M. D. or other) \_\_\_\_\_  
Address 726 W. Altamont Date signed 7/15/47

Physician  
Underline the cause to which death should be charged statistically

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

50M-5-17-39  
Rev. 1-1-39

15 15 1964

**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 Campbell* .....  
Licensed Embalmer No..... *3881* .....  
P. O. Address..... *4355 Washington Po* .....

**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, above space should be left blank.**