

FILED SEP 8 1947

100

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis Mo.

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

(c) Name of hospital or institution Pro's 20  
(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 St. Louis

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

(d) Street No. 924 No. 13 St.  
(If rural, give location)

(e) City of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Strang

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute 30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 44 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ark. (City, town or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER, FATHER

12. Name Wm Strang

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Wm Strang  
(b) Address 1300 Oak

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 8-20-47 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Wm Strang  
(b) Address 329 E. 19th

19. (a) \_\_\_\_\_ (Date received local registrar) \_\_\_\_\_ (b) J. J. Bruleck (Registrar's signature)

Due to Heat Exhaustion

Due to W.M.A.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause of 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? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

While at work \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Wm Strang (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 8/14/47

WRITE PLAINLY—USING 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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Heward F. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *St. Louis Mo*

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.