

Registration District No. 3063
FILED OCT 11 1947

Primary Registration District No. 3063

Registrar's No. 2028

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town CLAYTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 DAYS
(Specify whether years, months or days)

In this community 20 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis Co. 96

(c) City or town OVERLAND 13
(If outside city or town limits, write "RURAL")

(d) Street No. 8724 MAVIS PLACE 1
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME DELLA TOLBERT

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEP. day 19
year 1947 hour 12 minute P. M.

21. I hereby certify that I attended the deceased from SEP. 7
1947, to SEP. 19 1947;

that I last saw him ER alive on SEP. 19 1947;
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JASON

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased JULY 20 1881
(Month) (Day) (Year)

Immediate cause of death:

CEREBRAL THROMBOSIS Duration 13 days

CORONARY THROMBOSIS 8 days

PULMONARY EMBOLISM 7 days

Due to: CORONARY ARTERIO SCLEROSIS

CEREBRAL ARTERIO SCLEROSIS

DIABETIC GENERAL ARTERIO SCLEROSIS

PERIPHERAL VEIN THROMBOSIS 10 days

BRONCHO PNEUMONIA 3 days

Other conditions: _____
(Include pregnancy within 3 months of death)

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

66 1 29 hr. min.

9. Birthplace MT. CARMEL ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name FLETCHER TANQUARY

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

14. Maiden name MARY HERSWORTH

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

16. (a) Informant LEOLA KERCHER

(b) Address 8724 MAVIS PLACE

17. (a) Burial (b) Date thereof 9-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Ortman General

(b) Address Overland Mo.

19. (a) 9-30-47 (b) Debra J. May, M.D.
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: 61

Of operations _____

Of autopsy _____

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 _____ (Specify type of work) (Specify means of injury)

23. Signature Russell L. Hordner (M. D. or other) _____

Address 601 BRANTWOOD BLVD Date signed 9/27/47

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 al c Ortman

Licensed Embalmer No. 3478

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.