

No. 2
-1/47
5-17-39

FILED NOV 1 1947

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10177**

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution: **City Hospital**
(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..... **Missouri** (b) County..... **St. Louis**

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

(d) Street No. **4051 N. Elm Bl.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **JULIA PAUL**

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**

6. (b) Name of husband or wife..... **William**

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

7. Birth date of deceased..... **July 25 1882**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **3rd**
year **1947** hour **9:40** minute **A** M.

21. I hereby certify that I attended the deceased from **11/1/47**
to **Nov. 3rd 1947**

that I last saw him **or** alive on **Nov. 3rd 1947**
and that death occurred on the date and hour stated above.

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

65 3 8 hr. min.

Immediate cause of death **thrombosis left cerebral striate artery**

Due to **generalized arteriosclerosis**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Housewife**

Major findings: **§3**

Of operations.....

Of autopsy.....

PHYSICIAN.....

Underline the cause of which death should be charged statistically.

11. Industry or business.....

12. Name..... **Victor A. Bernes**

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

14. Maiden name..... **Leonora Chesley**

15. Birthplace..... **Chautauque New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rev. Walter Gunn**
(b) Address **1977 E. Adelaide Ave.**

17. (a) **Burial** (b) Date thereof **11-5-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

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..... (c) Means of injury.....

23. Signature **John W. Koehler** Date signed **11/9/47**
Address **1515 Lafayette**

18. (a) Signature of funeral director **Chas. G. Bull**
(b) Address **4355 Washington St.**

19. (a) **NOV 11 1947** (b) **J. J. Bernes**
(Date received from registrar) (Registrar's signature)

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.....

Rex Campbell

Licensed Embalmer No. *2881*

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. .