

S. No. 2
M-1/47
v. 5-17-39

36567

State File No.

National Office of Vital Statistics
FILED OCT 29 1947
Registration District No.

Primary Registration District No. 3070

Registrar's No. 2235

1. PLACE OF DEATH:

(a) County ST LOUIS

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

(c) Name of hospital or institution: 8
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State ILL (b) County JACKSON

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

(d) Street No..... (If rural, give location)

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

3. (a) PRINT FULL NAME EMMA I O'DANIEL

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex FEM 5. Color or race Wh

6. (a) Single, widowed, ~~married~~, divorced WID

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

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

7. Birth date of deceased JUNE 3, 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	4	17hr.min.

9. Birthplace JACKSON Co. - ILL
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business DAVID STEARNS

12. Name ILL

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

14. Maiden name MARY MULLIGAN

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

16. (a) Informant ERNEST F O'DANIEL

(b) Address R#1 CARBONDALE ILL

17. (a) REMOVAL (b) Date thereof 10-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CARBONDALE ILL

18. (a) Signature of funeral director E. J. Schmitt

(b) Address 3125 Lafayette

19. (a) 10-24-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1947 hour 6 minute 45 P.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.....
Cause unknown

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?..... (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 place)

23. Signature [Signature] (M. D. or M. P.)

Address Commissioner of Health Date signed 10-21-47

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

6
7
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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 _____

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.