

No. 2
1/47
17-39

7384

National Office of Vital Statistics

State File No.

FILED FEB 21 1948

Registration District No. 17

Primary Registration District No. 6076

Registrar's No. 472

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Afton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8149 Gravois Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1915 Union Blvd.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) /
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17
year 1948 hour 11 minute 55 A. M.

21. I hereby certify that I attended the deceased from
Jan. 14th, 1948 to Feb. 17th, 1948;
that I last saw her alive on Feb. 15th, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cerebral Hemorrhage 1 Mo.
(right side)

Due to.....
Due to.....

Other conditions Chr. Nephritis and 1 yr.
(Include pregnancy within 3 months of death)
Arteriosclerosis

Major findings:
Of operations..... no
Of autopsies..... no

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?.....
While at work?..... (Specify type of place)
(c) Means of injury.....

23. Signature W. H. Waller M.D.
Address 3608 S. Grand Blvd. Date signed 2/18/48

3. (a) PRINT FULL NAME Neva Day Hemenway
(b) If veteran, name war.....
(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 Joseph Hemenway 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Feb. 6, 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 0 11 hr. min.

9. Birthplace Chester Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business.....

12. Name Thomas Segar

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

14. Maiden name Adeline Day

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

16. (a) Informant Mrs. Mabel Dietrich

(b) Address 1915 Union Blvd.

17. (a) burial (b) Date thereof 2-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) 2-19-48 (b) Walter J. Segar
(Date received local registrar) (Registrar's signature)

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

PHYSICIAN
Underline the cause of which death should be charged statistically.

Duration

1 yr.

1 Mo.

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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: *Warren A. Carve*
Licensed Embalmer No. *3534*
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.