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5-17-39  
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#85409

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED MAY 15 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

138755  
State File No. \_\_\_\_\_  
Registrar's No. 4270

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(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:  
St. Louis City Hospital-Max C. Starkloff  
(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 \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. Memorial 415a East Marceau  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EULA BLUME  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: May 4th  
Month May day 4th  
year 1948 hour 9 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 5/1/48  
May 4th 1948, to May 4th 1948  
that I last saw her alive on May 4th 1948  
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 Widow  
6. (b) Name of husband or wife Adolph 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 5 1884  
(Month) (Day) (Year)

Immediate cause of death pericarditis  
heart disease Duration 3 yr.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions pericarditis  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
64 3 29 hr. \_\_\_\_\_ min.

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Tyler Texas  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Coon Kinsey  
13. Birthplace \_\_\_\_\_ Texas  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah O. Neil  
15. Birthplace \_\_\_\_\_ Georgia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mabel Scherrer  
(b) Address Route #14, Affton, Mo.

17. (a) Burial (b) Date thereof 5/7/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director Jos. P. Fendler Jr.  
(b) Address 7128 Michigan Ave.

19. (a) MAY 6 1948 (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

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 Frank J. Hartin (M. D. or other)  
1515 Lafayette 5/14/48  
Address Date signed

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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. 2906

P. O. Address. Michigan

**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.**