

FILED OCT 23 1948

318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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:
St. Louis City Hospital - ax. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOHN PRINDABLE**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **May 7th 1873**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	5	0	hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Teamster**

11. Industry or business.....

MOTHER FATHER { 12. Name **Daniel Prindable**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah O'Connor**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth Gorder**
(b) Address **5212 Vernon Ave.**
17. (a) **burial** (b) Date thereof **10-9-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Chas. F. Stuart Und. Co.**
(b) Address **1225 Union Blvd.**

19. (a) **OCT 8 1948** (b) **J. B. Forster**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5212 Vernon Ave.**
Memorial (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **7th**
year **1948** hour **10** minute **30 P** M.
21. I hereby certify that I attended the deceased from **9/17/48**
....., 19....., to **Oct. 7th**, 19 **48**
that I last saw him alive on **Oct. 7th**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to **Pyelonephritis**
non-calculous
Chronic Benign
Prostatic hypertrophy
Other conditions.....
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations.....
Of autopsy.....
137

PHYSICIAN

Underline the cause to 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?
While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature **W. Reagan** 1515 Lafayette 10/8/48
Address..... Date signed.....

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

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 J. W. Wilkinson
Licensed Embalmer No. 3575
P. O. Address H. Louis M.

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.