No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34957

FILED NOV 9 1948

Registration District No. 19487

Primary Registration District No. 3069

Registrar's No. 2-07

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmonds Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether
In this community 3 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Webster Groves, 7
(If outside city or town limits, write "RURAL")
(d) Street No. 476 Hawthorne Ave. 4
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Rosalie Blanchard
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife William L. Blanchard
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 13 (Day) 1863 (Year)

8. AGE: Years 82 Months 11 Days 17 If less than one day hr. min.

9. Birthplace Cassoplis (City, town, or county) Mich. (State or foreign country)
10. Usual occupation At Home
11. Industry or business
FATHER
12. Name Frank Carrier
13. Birthplace Unknown (City, town, or county) S. Dakota (State or foreign country)
MOTHER
14. Maiden name Sarah Bonine
15. Birthplace Unknown (City, town, or county) Mich. (State or foreign country)
16. (a) Informant Mrs. Kathleen Heineman
(b) Address 476 Hawthorne Ave.
17. (a) Cremation (Burial; cremation, or removal) (b) Date thereof Oct. 29, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory
18. (a) Signature of funeral director Parker Und. Co.
(b) Address Webster Groves, Mo.
19. (a) 10-29-48 (Date received local registrar) (b) Cecil C. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27
year 1948 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from October 9, 1948, to October 27, 1948
that I last saw her alive on October 26, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung — Duration 1 year
Due to Chronic Cholecystitis and Cholelithiasis Cont. Hern.
Due to
Other conditions (Include pregnancy within 3 months of death) 47d
Major findings:
Of operations
Of autopsy as above

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. A. Goodrich (M. D. or other)
Address 19 E. Lockwood Av. Date signed 10/29/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Webster Groves Mo

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.