

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **44 days** (Specify whether
In this community **Life** (Specify whether
years, months or days)

3: (a) PRINT FULL NAME **Julia Topp**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **femal 3** 5. Color or race **Col**
6. (a) Single, widowed, married, divorced **Widowed 2**
6. (b) Name of husband or wife **William Topp** 6. (c) Age of husband or wife if
62 years
7. Birth date of deceased **Sept 26 1889**
(Month) (Day) (Year)

8. AGE: Years **39** Months **3** Days **16** If less than one day
hr. min.

9. Birthplace **St. Louis Mo** (City, town, or county) (State or foreign country)
10. Usual occupation **House Wife**

11. Industry or business _____
12. Name **George Lewis**
13. Birthplace **Mo** (City, town, or county) (State or foreign country)
14. Maiden name **Julia**
15. Birthplace **Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **William Topp**
(b) Address **1403 Walton Ave**
17. (a) **Burial** (b) Date thereof **12/17/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peter's Cemetery**

18. (a) Signature of funeral director **Harman J. Smith**
4247 1/2 Labadie Ave
(b) Address
19. (a) **DEC 14 1948** (b) **J B Lanster**
(Date received local file) (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 **1403 Walton** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **12**
year **1948** hour **11** minute **5** P.M.

21. I hereby certify that I attended the deceased from
Oct. 29, 19**48**, to **Dec. 12**, 19**48**
that I last saw her alive on **Dec. 12**, 19**48**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Lungs, Intestines and Spleen -- Tuberculosis** Duration **Undet.**

Due to _____
Due to _____
Other conditions **Chronic Pyelonephritis** **Undet.**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy **Yes**
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 **Nicar J Daniels** (M. D. or other) _____
Address **2601 N Whittier** Date signed **12/13/48**

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

MOTHER FATHER

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.....

..... 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.