

No. 2
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5-17-39
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FILED MAY 3 1945
Registration District No. 318

Primary Registration District No. 1003

State File No. _____
Registrar's No. 3705

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(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: Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Caroline J. Pinkston

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John W. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 23rd, 1860
(Month) (Day) (Year)

8. AGE: Years 84 Months 10 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm. H. Wooldridge

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

14. Maiden name Celia Janis

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

16. (a) Informant Mrs. Mayme Thomas
(b) Address 5427 Holly Hills

17. (a) Burial (b) Date thereof 4/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farmington, Mo.

18. (a) Signature of funeral director Kraeger-Voss-Fox
(b) Address 3402 N. Kingshighway

19. (a) APR 26 1945 J. F. Bruck
(Date received local Registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis, Mo.
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 5427 Holly Hills
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th
year 1945 hour 10 minute 32 M.

21. I hereby certify that I attended the deceased from April 19, 1945, to April 24, 1945
that I last saw her, alive on April 24, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (Right Hemiplegia) Duration 6 days

Due to Generalized Arteriosclerosis indefinite

Due to _____ indefinite

Other conditions Note exception Chronic Cardio-Vascular-Renal disease indefinite
(Include pregnancy within 3 months of death)

Major findings: Cardio-Vascular-Renal disease
Of operations None

Of autopsy None

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? _____

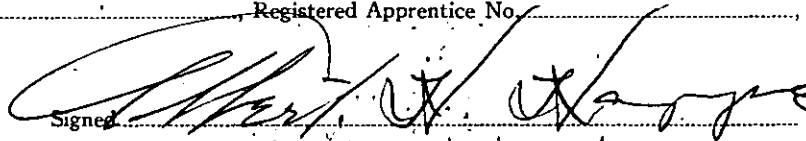
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Leon C. Hail (M. D. or other) M.D.
Address 1524 So. Grand Blvd. Date signed 4-25-45

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. 1861

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.