

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

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town CLAYTON  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
142 N. BEMISTON 1  
(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 ST. LOUIS <sup>9/6</sup>

(c) City or town CLAYTON <sup>2</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 142 N. BEMISTON <sup>3</sup>  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) <sup>0</sup>

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PEARL PINE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced W <sup>2</sup>

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: July 25 1890  
(Month) (Day) (Year)

8. AGE: Years 55 Months 7 Days 20  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace DOERUN MO U  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm O'Sullivan

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

14. Maiden name SARAH M. HUNT

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

16. (a) Informant Wm. O'Sullivan

(b) Address 142 N. Bemiston - Clayton

17. (a) BURIAL (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FARMINGTON, MO.

18. (a) Signature of funeral director Rene N. Bopp

(b) Address 131 W. Argonne - Kirkwood

19. (a) 3-19-46 (b) EBM Garrison MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 15  
year 1946 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 7  
1946 to Mar 14 1946

that I last saw her alive on Mar 13 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage <sup>43 yr</sup>

Due to Precocious anemia and a complication of disease

Due to Arthritis <sup>43 yr</sup>

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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 Rose Minnie Rose (M. D. or other) M. D.

Address 5301 A Easton Ave Date signed 3/16/46

**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..... *Jan M. Sizemore* .....

Licensed Embalmer No. *4343* .....

P. O. Address..... *7415 Zephyr Pl  
Maplewood, 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.**