

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36345
Do not use this space.

NOV 15 1937

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1008

Registered No. 9922

1. PLACE OF DEATH **Romer G Phillips Hospital**

(a) County Registration District No. **1**

(b) Township Primary Registration District No. **1008**

(c) City **St. Louis** (d) Street No. **2601** N. Whittier St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred **10** yrs. mos. ds. **0** How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Helen Cannon**

(a) Residence, No. **2618 Stoddard** St. **21**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F**

4. COLOR OR RACE **C**

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **unknown**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov. 28, 1893**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 9 22

8. Trade, profession, or particular kind of work done, as **housework**
sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

13. NAME **Anderson Burdine**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

15. MAIDEN NAME **Ruth Pruitt**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

17. INFORMANT (ADDRESS) **Evelyn Hilliard 2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Supels, Miss** DATE **10-26-37**

19. FUNERAL DIRECTOR (ADDRESS) **A. J. Walton 2702 Stoddard St**

20. FILED **OCT 26 1937** **J. Bredeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct, 20**, 19 **37**

22. I HEREBY CERTIFY, That I attended deceased from **Sept. 22**, 19 **37**, to **Oct. 20**, 19 **37**

I last saw him **et** alive on **Oct. 20**, 19 **37** Death is said to have occurred on the date stated above, at **6:43** m. **p.m.**

The principal cause of death and related causes of importance were as follows:

Post operative peritonitis following hysterectomy by Richard of non dependent abdominal tumor of uterus

Other contributory causes of importance: **548**

Name of operation Date of operation

What test confirmed diagnosis? **clinical** Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? C

If so, specify **Thomas C. McFall**, M. D.
(Signed) (Address) **2601 N Whittier**

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STATEMENT BY LICENSED EMBALMER

I, Arthur L. Hilliard

Licensed Embalmer No. 3389

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed Arthur L. Hilliard

Licensed Embalmer No. 3389

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.)