

REC'D FEB 10 1939

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

204

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **Homer Phillips Hospital** 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 **53** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **204****2. PRINT FULL NAME**

400 **Susie Caloway**
 (a) Residence, No. **4210 West Belle Ave** St. **11**
 (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)
Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 2, 1881**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 6 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**
 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) **Missouri**

FATHER 13. NAME **unknown**

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

MOTHER 15. MAIDEN NAME **Mary Hoskins**

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

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

18. BURIAL, CREMATION, OR REMOVAL PLACE **Greenwood** DATE **Jan 9, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **J. H. Harrison**
29039 Lexington

20. FILED **JAN 19 1939**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 3, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Dec. 23, 1938** to **Jan. 3, 1939**

I last saw her alive on **Jan. 3, 1939**. Death is said to have occurred on the date stated above, at **2:30 a. m.**

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

Encapsulated cerebral hemorrhage Date of onset **12/23/38**

Other contributory causes of importance:
Benign degeneration of cord

Name of operation..... Date of.....
 What test confirmed diagnosis? **clinical**. Was there an autopsy? **NO**

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?.....
 If so, specify.....

(Signed) **Herbert Egan**, M. D.
 (Address) **2601 N Whittier**

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Jas. H. Harrison

Licensed Embalmer No. 760

P. O. Address 2906 Lawton

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, above space should be left blank.