

Registration District No. **791**

Primary Registration District No. **1003**

**4484**

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

**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 25 days  
(Specify whether  
 In this community 24 years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 21  
(If outside city or town limits write "RURAL")  
 (d) Street No. 3213a Bell  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Cora Stevenson 315

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

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

6. (b) Name of husband or wife John Stevenson 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 50 Months 9 Days 9 If less than one day hr. 5 min. \_\_\_\_\_

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

10. Usual occupation House Wife

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

MOTHER FATHER { 12. Name Caleb Harrison /

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

14. Maiden name Maggie Mc Clelland

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

16. (a) Informant Viola Campbell

(b) Address 5912 S. Parkway Bldg.

17. (a) \_\_\_\_\_ (b) Date thereof 5-22-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Wood Cemetery

18. (a) Signature of funeral director Mrs. Lowe

(b) Address 2930 Dickson St

19. (a) MAY 20 1940 (b) J. F. Seelach  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 5 day 17  
 year 1940 hour 10 minute 20 A. M.

21. I hereby certify that I attended the deceased from 4-22- 1940 to 5-17- 1940;  
 that I last saw her alive on 5-17- 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease About 3 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

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

**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 H. J. Eymann (M. D. or other) 1  
 Address 2601 N. Whittier St. Date signed 5-20-1940

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

**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 *Robert H. Powell*

Licensed Embalmer No. *3402*

P. O. Address *3100 Franklin*

**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.**