No. 2
11-10-10
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23641

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 6086

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

1. PLACE OF DEATH:

(a) County
(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: 1302 Armstrong Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 1302 Armstrong
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Josie Ola Ivy 100

3. (b) If veteran, name war None

3. (c) Social Security No. None.

4. Sex Female

5. Color or race Colored

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive None years

7. Birth date of deceased 1 (Month) 5 (Day) 1940 (Year)

8. AGE: Years 30 Months 6 Days 12 If less than one day hr. min.

9. Birthplace West Point (City, town, or county) Miss (State or foreign country)

10. Usual occupation House work

11. Industry or business None.

FATHER
12. Name Ceder Bell
13. Birthplace unknown (City, town, or county) Miss (State or foreign country)

MOTHER
14. Maiden name Alex Crum
15. Birthplace unknown (City, town, or county) Miss (State or foreign country)

16. (a) Informant Lillian Coleman
(b) Address 1302 Armstrong.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-20-40 (Month) (Day) (Year)
(c) Place: burial or cremation West Point Miss

18. (a) Signature of funeral director Mary Wade
(b) Address 4202 Fyhney Ave

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

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from 7-16- 1940 to 7-17- 1940 that I last saw her alive on 7-17- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis — Duration 1 yr.
Due to Exposure
Due to Exposure
Other conditions no
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy no

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) no
(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 L. E. Vincent (M. D. or other)
Address 2336a Market Date signed 7-19-40

(Licensed Embalmer's Statement on Reverse Side)

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 S J Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Charited

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.