

V. S. M. Rev. 5-17-39 I X 2492

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

AUG 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

24009

Registration District No.

Primary Registration District No.

Registrar's No.

6454

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 1
In this community 1 yr (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 0 5375 MAPLE (If rural, give location)
(e) If foreign born, how long in U.S.A. 21 5 years.

3. (a) PRINT FULL NAME ADOLSKA MACERING

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 day 27
year 1940 hour 6.45 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: 5 (Month) 10 (Day) 1900 (Year)

8. AGE: Years 40 Months 2 Days 17 If less than one day 6 hr. 15 min.

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

10. Usual occupation MKID

11. Industry or business _____

MOTHER FATHER
12. Name WILL BROWN
13. Birthplace MISSISSIPPI
14. Maiden name ELIZABETH
15. Birthplace MISSISSIPPI

16. (a) Informant ORA PINKNEY
(b) Address 3168 EASTON AVE

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG 1, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Boyd Bros
(b) Address 317 1/2 Finney Ave

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

Immediate cause of death Myocardial infarction and atherosclerosis
Due to apoplexy
Other conditions gna
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) (b) Means of injury _____
23. Signature Joseph J. Finney
Address _____ (Print name)

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

1237

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

Louis V. Atkins

Licensed Embalmer No.

2842

P. O. Address

3644 Finney Ave

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24009**
Registrar's No. **6457**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **791**

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days)

3. (a) PRINT FULL NAME **ADLISNA McGEORING**

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

4. Sex **F** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years **40** Months **2** Days **17** If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **11-25-40** (Date received local registrar) (b) **J. F. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

DECLARATION OF DEATH

20. DATE OF DEATH Month **7** day **27** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 **Joseph M. DeJura** (other) _____

Address **11 Deputy Coroner**

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

