

FILED JAN 15 1941 791

Registration District No.

Primary Registration District No.

1003

Registrar's No.

9844

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: Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
In this community 25 yrs
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. 3519 Laclede
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27
year 1940 hour 8:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from
November 14, 1940 to November 27, 1940
that I last saw her alive on November 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix Indef

Due to _____

Due to _____

Other conditions H/O
(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)
(c) Means of injury _____

23. Signature Leon A. Smart (M. D. or other) _____
Address 2601 N Whittier Date signed _____

3. (a) PRINT FULL NAME Gertrude Porter

3. (b) If veteran, name war Nil 3. (c) Social Security No. 197-07-9491

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

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

7. Birth date of deceased February 27, 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 9 1 _____ hr. _____ min.

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

10. Usual occupation Laundress

11. Industry or business National Laundry Co. 9

12. Name Unknown 9

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Grace Harrison

(b) Address 3419 Laclede Avenue.

17. (a) Burial (b) Date thereof 12/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director [Signature]

(b) Address 3517 Laclede Ave

19. (a) 1 1940 (b) [Signature]
(Date received local registration) (Registrar's signature)

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

MOTHER FATHER

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.....

Licensed Embalmer No. 1173

P. O. Address 3517 S. Clede

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, fact should be so stated above.