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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5262

State File No.

MAR 25 1941

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1510

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: St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin 999

(c) City or town West Frankfort NA
(If outside city or town limits, write "RURAL")

(d) Street No. 723 Washington Blvd
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME Sheron Lynn Tweedy

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race wht

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 12 (Month) 5 (Day) 40 (Year)

8. AGE: Years | Months 24 | Days 9 | If less than one day hr. min.

9. Birthplace W. Frankfort, Illinois / (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER

12. Name Boyd Elbert

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

14. Maiden name Imogene Quarles

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

16. (a) Informant Patricia Moore

(b) Address St L. Children's Hospital

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-14-41 (Month) (Day) (Year)

(c) Place: burial or cremation West Frankfort Ill

18. (a) Signature of funeral director Union Funeral Home

(b) Address West Frankfort Ill

19. (a) (Date received local registrar) J. Wedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 14 year 41 hour 9:15 minute a M.

21. I hereby certify that I attended the deceased from 1-22, 1941, to 2-14, 1941; that I last saw h alive on 2-14-41, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Miliary tuberculosis — 3 wks
Pulmonary tuberculosis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)
Foreign Body (safety pin) in esophagus

Major findings:
Of operations

Of autopsy

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

(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 J. Wm Bunkley

Licensed Embalmer No. 365

P. O. Address St. Louis Mo

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, fact should be so stated above.