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FILED APR 21 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9186

State File No. \_\_\_\_\_  
Registrar's No. 2596

Registration District No. 791

Primary Registration District No. 1003

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 6 days  
(Specify whether \_\_\_\_\_)  
In this community 13 years  
years, months or days)

3. (a) PRINT FULL NAME Rosie Hawkins  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased December 25, 1879  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
61 2 22 hr. min.

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

10. Usual occupation House work

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

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Unknown Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Margah Thurman  
15. Birthplace St. Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Ellen West  
(b) Address 3231 Laclede Ave

17. (a) Burial (b) Date thereof 3-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director F. A. Green  
(b) Address 2915 Franklin Ave

19. (a) MAR 24 1941 (b) F. J. Budack  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 21000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 9  
(d) Street No. 3231 Laclede Ave.  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th  
year 1941 hour 6:20 minute P. M.

21. I hereby certify that I attended the deceased from March 13, 19 41 to March 19, 19 41;  
that I last saw her alive on March 19, 19 41;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease 8 years  
Duration

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

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

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? \_\_\_\_\_

While at work (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature Clarence (M.D. or other) \_\_\_\_\_  
Address 2601 N. Whittier St. Date signed 3-20-41

**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. *2963*

P. O. Address *2915 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, fact should be so stated above.**