

STANDARD CERTIFICATE OF DEATH

State File No. 16635

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4153

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 11  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether \_\_\_\_\_)  
In this community 21 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 27  
(If outside city or town limits, write "RURAL") 9  
(d) Street No. 1143 N. Leonard  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14  
year 1941 hour 6:00 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from  
May 11, 1941 to May 14, 1941  
that I last saw h. er alive on May 14, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Strangulated Epiplocele 1 wk.  
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 W. E. A. Jordan (M.D. or other) J  
Address 2601 N. Whittier St. Date signed 5-16-41

3. (a) PRINT FULL NAME Mary Emma Knox TORAN

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Eugene Toran 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Feb. 15, 1904  
(Month) (Day) (Year)

8. AGE: Years 37 Months 2 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housework

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

MOTHER FATHER { 12. Name Thomas Lind

18. Birthplace Miss. /  
(City, town, or county) (State or foreign country)

14. Maiden name Amie Living

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

16. (a) Informant Georgia Anna Ray

(b) Address 1143 N. Leonard Ave

17. (a) Shipped (b) Date thereof 5-19-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest City, Ark.

18. (a) Signature of funeral director Dement & Son

(b) Address 2620-31 Cole Street

19. (a) MAY 17 1941 (b) J. W. Bradech  
(Date received local registrar) (Registrar's signature)

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

10  
7  
5

**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

*H. A. [Signature]*

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, above space should be left blank.**