

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 28 1941
On District No. 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 23089
Registrar's No. 5441

1. CAUSE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of Hospital or institution:
Peoples Hospital
(If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 2 months 21 Days
6 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Grace Dell Clark Rollins

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

4. Sex Female 5. Color or race Negro 6. (a) ~~Single, widowed, married~~ 3 divorced, widowed

6. (b) Name of husband or wife Jack Rollins 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased Sept 16, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>52 45</u>	<u>1928</u>	<u>10</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business George McCane

12. Name Gonzales Texas

18. 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's own signature Chas Clark

(b) Address 4210A Enright Ave.

17. (a) Burial (b) Date thereof July 2, '41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director Glenn Underhill

(b) Address 3849 Windsor Plaza

19. (a) Date received from Registrar 2/2/41 (b) Registrar's signature J. H. Breakey

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County _____

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4210 a Enright ave
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29th
 year 1941 hour 9:00 minute _____ A. 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 Pulmonary Thrombosis
Pulmonary infarction and old fractures of right leg and Pelvis, suffered when the Ford automobile driven by one Ollie Dickson (Col) in which she was a passenger, collided with a Page Avenue streetcar driven by one Elmer Gehlert, at Whittier and Finney A. out 8:00 o'clock A.M., April 8, 1941.

Other conditions (Include pregnancy within 5 months of death) ACCIDENT.

Major findings: 10 b-s
 Of operation _____
 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) Accident

(b) Date of occurrence 4/8/1941

(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Thomas H. Callahan (M. D. or other)

Address Deputy Coroner Date signed 7/2/41

SEP 17 1940

AUG 13 1940

AUG 14 1940
SEP 17 1940

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed Clark Young

Licensed Embalmer No. 3370

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

St Louis

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23089
Registrar's No. 5441

Registration District No. 791

Primary Registration District No. 1003

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: Peoples Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Grace D. C. Robbins

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

4. Sex F 5. Color or race A 6. (a) Single, widowed, married, divorced Divorced

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 _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-29-41 (b) J. J. Bredeck
(Date received local registrar) (Registrar's signature)

Immediate cause of death _____
Duration _____

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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

S-23089