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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36931

State File No. _____
Registrar's No. **9161**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Mo.**
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 mos. 22 days**
In this community **13 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
(c) City or town..... **St. Louis, Mo.**
(d) Street No. **2925 Dayton**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Roberta Greer**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced..... **4**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... **3 10**
(Month) (Day) (Year)

8. AGE: Years **60** Months **8** Days **5** If less than one day hr. min.

9. Birthplace..... **Jackson** **Miss**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Seamstress**

11. Industry or business..... **At home.**

MOTHER { 12. Name..... **Alexander**
13. Birthplace..... **Miss**
(City, town, or county) (State or foreign country)
14. Maiden name..... **UNK**
15. Birthplace..... **Miss**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **William Max Sawkins**
(b) Address..... **2944 GASTON AVE.**

17. (a) **Burial** (b) Date thereof **10-19-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **Green wood.**

18. (a) Signature of funeral director..... **Mary Wade**
(b) Address..... **4202 Finney Ave.**

19. (a) **NOV 18 1941** (b) **J. F. Brubaker**
(Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **15,** 1941
year..... hour..... **10** minute **40** A..... M.

21. I hereby certify that I attended the deceased from **March 24,** 1941
to **Nov. 15,** 1941
that I last saw him **or** alive on **November 15,** 1941
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Glomerular nephritis with Hypertension - Chronic

Due to.....
Duration **Unk.**

Other conditions..... **131**
(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 **J. W. Johnson** (M. D. or other)
Address **2801 N. Whittier** Date signed **11-17-41**

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

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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. *269A*

P. O. Address *2769 Chouinard*

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.