

FILED FEB 24 1942 791

Registration District No. _____ Primary Registration District No. **1005**

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:
Homer G. Phillios Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 days**
(Specify whether
 In this community **41 years**
years, months or days)

3. (a) PRINT FULL NAME **Alma Poston**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **N11**

4. Sex **Female** 5. Color or race **Col**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **John Poston**
 6. (c) Age of husband or wife if alive **Deceased**
 7. Birth date of deceased **Abt 1900**
(Month) (Day) (Year)

8. AGE: Years **Abt. 41**
 Months _____ Days _____
 If less than one day
 hr. _____ min. _____

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

10. Usual occupation **Housework**

11. Industry or business **At Home**

12. Name **Unknown**

13. 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 **Drucilla Young**

(b) Address **3851a Evans Ave.**

17. (a) **Burial** (b) Date thereof **1/31/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **E. St. Louis, Ill**

18. (a) Signature of funeral director **R. M. C. Green**

(b) Address **3517 Laclede Ave.**

19. (a) **FEB 20 1942** (b) **J. F. Brudick**
(Date for burial or cremation) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **660**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3337a Market**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **24**,
 year **1942** hour _____ minute **45** P. M.

21. I hereby certify that I attended the deceased from **January 16**,
1942 to **January 24**, **1942**;
 that I last saw her alive on **January 24**, **1942**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease with De compensation**
 Duration **Unknown**

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 **J. W. Johnson** (M. D. or other) **O**

Address **2601 Webster** Date signed **1/26/42**

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

AP Richardon

icensed Embalmer No.

2928

P. O. Address

2675 Glasgow

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.