

FILED AUG 11 1942

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22968

791

1003

State File No. ....

Registrar's No. **6414**

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 Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 15 days  
(Specify whether  
 In this community. 47 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
17  
 (c) City or town St. Louis, 918  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2911 Laclede  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME Mary Moore  
 3. (b) If veteran, name war.....  
 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3,  
 year 1942 hour 7 minute 30 P.M.  
 21. I hereby certify that I attended the deceased from June  
18, 19 42 to July 3, 19 42  
 that I last saw her alive on July 3, 19 42  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Colored  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife.....  
 6. (c) Age of husband or wife if alive..... years

Immediate cause of death  
Prob. Carcinoma of Rectum  
 Duration Unknown

7. Birth date of deceased. Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
abt. 79 hr. min.

Due to.....  
 Due to.....

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

Other conditions.....  
(Include pregnancy within 3 months of death)

10. Usual occupation.....

PHYSICIAN

Major findings:  
 Of operations.....  
 Of autopsy.....  
 Underline the cause to which death should be charged statistically.

11. Industry or business NIL

MOTHER FATHER { 12. Name Joshua Gates  
 13. Birthplace Ga. 1  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith  
 (b) Address 2601 N. Whittier St.

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?

17. Anatomical 7-10-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

While at work? 0 (Specify type of place)  
 (e) Means of injury.....

18. (a) Signature of funeral director. J. W. Ruffin  
 (b) Address.....  
 19. (a) III 30 1942 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

23. Signature J. E. Smith (M. D. or other).....  
 Address 2601 N. Whittier Date signed.....

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

**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.....

P. O. Address.....

**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.