

FILED SEP 4 1942

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis, Mo.
(c) Name of hospital or institution: St. Mary and Carmel
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County.....
(c) City or town..... St. Louis
(d) Street No. 2825 Lucas Ave.
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Childs Josephine

3. (b) If veteran, name war..... (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 Brady Childs 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased Nov 20 1910
(Month) (Day) (Year)

8. AGE: Years 31 Months 7 Days 3 If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country) Ark 1

10. Usual occupation Home Wife

11. Industry or business.....

MOTHER FATHER { 12. Name Sam Brown
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)
14. Maiden name Mary Clark
15. Birthplace Ark 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mary Brown
(b) Address 26411 Scott

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-1942
(Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Fred Green
(b) Address 2915 Franklin Ave

19. (a) AUG 28 1942 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 23 year 1942 hour 11 A.M. minute..... M.

21. I hereby certify that I attended the deceased from Aug 21 1942 to Aug 23 1942
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency

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

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

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

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

23. Signature J. H. Hysman (M. D. or other) J. H. Hysman
Address 304 E. Easton Date signed 8-20-42

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

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17
9

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

884

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: *E. A. Hester*

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, fact should be so stated above.