

REGISTRATION DISTRICT NO. **1818**

PRIMARY REGISTRATION DISTRICT NO. **1003**

STATE FILE NO. _____

REGISTRAR'S NO. **350**

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

1. PLACE OF DEATH:

(a) County _____
 (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 **5 days**
(Specify whether years, months or days)
 In this community **18 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2502 N. Newstead Ave.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Mamie McDaniel**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Fem** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced, **Married**

6. (b) Name of husband or wife **Monroe McDaniel** 6. (c) Age of husband or wife if alive **Deceased** years

7. Birth date of deceased **August 2, 1904**
(Month) (Day) (Year)

8. AGE: Years **38** Months **4** Days **29** 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 **Tom McCoy**

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

14. Maiden name **Mary Jane Bell**

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

16. (a) Informant **Mary Jane Dozier** Ill

(b) Address **1123 Kansas Ave., E. St. Louis**

17. (a) **Burial** (b) Date thereof **1/14/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem.**

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

(b) Address **3517 Laclede Ave**

19. (a) **Jan 13 1943** (b) **J F Beedeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **9** year **43** hour _____ minute **30** AM/PM

21. I hereby certify that I attended the deceased from **Dec 106** 19**43** to **Jan 9** 19**43**

that I last saw him alive on **Jan 9** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertension**

Due to _____

Due to **1/12**

Other conditions _____

(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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 **Walton** (M. D. or other) _____
 Address **2516 4th St** Date signed **1/12/43**

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

W. M. Sheen

Licensed Embalmer No. *1173*

P. O. Address *3517 Soledad Ca*

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.