TMENT OF COMMERCE
UREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4859

Registration District No. EL MAR 15 1943

Primary Registration District No.

Registrar's No. 2073

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County St Clair
(c) City or town East St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 222 Rear Bowman
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME Susie Tibbs

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Isaiah Tibbs

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Dec (Month) 1 (Day) 1892 (Year)

8. AGE: Years	Months	Days	If less than one day
50	2	27	hr. min.

9. Birthplace Giles County Tenn (City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business Own home

MOTHER FATHER
12. Name Mack Robinson
13. Birthplace Tenn (City, town, or county) (State or foreign country)
14. Maiden name Mollie Robinson
15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant's own signature x J. Tibbs
(b) Address 222 Rear Bowman Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3 1943 (Month) (Day) (Year)
(c) Place: burial or cremation East St Louis Ill

18. (a) Signature of funeral director Crippler-Adams
(b) Address 1518 Pagett East St Louis, Illinois

19. (a) MAR 6 1943 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28 year 1943 hour 6 minute 15 M.

21. I hereby certify that I attended the deceased from Feb. 18, 1943, to Feb. 28, 1943, that I last saw her alive on Feb. 28, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal Obstruction & Gangrenous bowel. (Operated)	7 days
Due to Previous Operation	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Intestinal Obstruction & Gangrenous bowel
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature N. G. Hagler (M. D. or other)
Address 2409 Kansas Ave Date signed 3/7/43

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY—USE UNFADING INK. MAKE A PERMANENT RECORD

Form Y X19511

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. 3518

P. O. Address East St Louis, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4859
073

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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: St Mary's Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County St. Clair
(c) City or town East St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 222 Rear Bowman
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Susie Tibbs
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex F
5. Color or race B
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive .....
7. Birth date of deceased Dec -1- 1892 (Month) (Day) (Year)
8. AGE: Years 50 Months 2 Days 22 If less than one day ..... hr. ..... min.
9. Birthplace ..... (City, town, or county) Tenn (State or foreign country)
10. Usual occupation .....
11. Industry or business .....

MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) MAR 29 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19..... ; that I last saw h..... alive on ..... 19..... ; and that death occurred on the date and hour stated above.
Immediate cause of death ..... Duration
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY