DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22880

FILED JUL 31 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6552

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days (Specify whether years, months or days)
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96 7

(c) City or town Webster Groves 4
(If outside city or town limits, write "RURAL")

(d) Street No. 513 Holland
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Aline Conway

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased January 27, 1900 (Month) (Day) (Year)

8. AGE: Years 43 Months 5 Days 20 If less than one day hr. min.

9. Birthplace Festus, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Ollie Sparks
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Stella Williams
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

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

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-43 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Greenwood Cem

18. (a) Signature of funeral director J C Lewis
(b) Address 22 Concord Webster Groves

19. (a) JUL 20 1943 (Date received local registrar) J H Redel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17, year 1943 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from June 30, 1943 to July 17, 1943; that I last saw her alive on July 17, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Adeno-Carcinoma of Ovary with metastasis to abdominal wall	1 year
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 S. E. Lynch (M. D. or other)
Address 20 Whittier Date signed 7/19/43

(Licensed Embalmer's Statement on Reverse Side)

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 J. Lewis

Licensed Embalmer No. 2027

P. O. Address Webster Groves

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, fact should be so stated above.

FOLD HERE

No. 2B
—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6552

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

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alice Conway
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 Married
6. (b) Name of husband or wife Stephens
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 27 (Day) 1899 (Year)
8. AGE: Years 43 Months 5 Days 25 Unless than one day min.
9. Birthplace (City, town, or county) MO (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)
MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 27 year 1943 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

ONLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

5-22880