

FILED JAN 3 1944

State File No.

Registrar's No.

11529

Registration District No.

318

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 34 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
1942a Papin St.
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19,
year 1943 hour 1 minute 00 P. M.
21. I hereby certify that I attended the deceased from December
15, 19 43 to December 19, 19 43
that I last saw h. er alive on December 19, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death
Rheumatic Heart Disease
Chr. Nephritis

Duration

Unk.

"

Due to a
Due to 131
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature S. E. Smith (M. D. or other)
Address 2601 Whittier Date signed 1/2/44

3. (a) PRINT FULL NAME

Amanda Boykins

3. (b) If veteran, name war

NO

3. (c) Social Security No. 710

4. Sex F. M. Color or race 3 negro 6. (a) Single, widowed, married, divorced 1 married

6. (b) Name of husband or wife A. Jim Boykin (c) Age of husband or wife if alive 55 years

7. Birth date of deceased May (Month) 18 (Day) 1895 (Year)

8. AGE: Years 48 Months 7 Days 1 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

12. Name Robert Spann

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

14. Maiden name Martha Spann

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

16. (a) Informant Robin Lee Boykin

(b) Address 1755 Love Joy Lane

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.22.43 (Month) (Day) (Year)

(c) Place: burial or cremation Burial in the Oak Grove

18. (a) Signature of funeral director A. N. Burks

(b) Address 1600 S 3rd St.

19. (a) DEC 22 1943 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

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

MOTHER FATHER

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.....

Amelia A. Johnson
Licensed Embalmer No. 3592

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.