

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 11 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1063

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:
The St. Louis Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution FROM 2 P.M.,
1-31-1944 to 6:15 P.M., 1-31-1944.
In this community _____
years, months or days)

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. 2609A Delmar Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AZALINE KILLIAN

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased February 13 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
11 18 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name George W. Killian
13. Birthplace Arkansas
14. Maiden name Sally Bee Bush (State or foreign country)
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Edith V. Minor
(b) Address 5600 Arsenal Street.

17. (a) Burial (b) Date thereof 2-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director Ellis Furr's Home

(b) Address 2820 Stoddard St

19. (a) FFB (b) J. J. Bredert
(Date recorded) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31
year 1944 hour 6: minute 15 M.

21. I hereby certify that I attended the deceased from 2 P.M. 1-31,
1944 to 6:15, 1-31-1944
that I last saw her alive on January 31, 1944, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration _____
Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy as given above

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 Dr. Maxwell (M. D. or other) _____
Address St. Louis Isolation Hosp Date signed 2-1-44

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 my self

Lonnie Boykin, Registered Apprentice No. _____
working under my personal supervision.

Signed Lonnie Boykin

Licensed Embalmer No. 2946

P. O. Address St Louis Mo.

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.