

S. No. 2
M-2-43
5-17-39
-I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **5125**
Registrar's No. **1632**

FILED MAR 1 1944
318
Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1015 Bates St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
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. 1015 Bates St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Effie May Fulford
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 17th
year 1944 hour 10 minute 45 P.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Franklin P. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 19 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 2 1943, to Feb 17 1944
that I last saw her alive on Feb 17 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
65 2 28 _____ hr. _____ min.

Immediate cause of death: Cerebral Hemorrhage Duration 6 mo
Due to: Hypertension 6 mo
Due to: _____
Other conditions: Ch. Myocarditis 6 mo
(Include pregnancy within 3 months of death)

9. Birthplace Illinois (City, town, or county) (State or foreign country)
10. Usual occupation At Home

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name William Foster
13. Birthplace Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Don't Know
15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant Eugene Harper
(b) Address 1015 Bates St.
17. (a) Removal (b) Date thereof 2/21/44
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Springerton Ill.
18. (a) Signature of funeral director Gelken + Perry Mortuary
(b) Address 2842 Meramec St.
19. (a) FEB 18 1944 (b) J. Medeck
(Date received local Registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature E. J. ... (M. D. or other) MD
Address 5417 So Grand Blvd Date signed 2/18/44

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Joe S. Benz

Licensed Embalmer No. 4249

2842 Meramec St.

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.