

S. No. 2
M-5-43
5-17-39
P I X36671

FILED MAR 6 1944 8 18

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **2022**

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 G Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo; 15 days
(Specify whether years, months or days)

In this community Unknown

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. 5800 Arsenal
(If rural, give location)

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

3. (a) PRINT FULL NAME Blanche Hall

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Female **5. Color or race** 3 Negro **6. (a) Single, widowed, married, divorced** Single

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

7. Birth date of deceased Unknown 1909
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>abt 34</u>	<u>-</u>	<u>-</u>	hr. min.

9. Birthplace _____ Unknown 7
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER

12. Name Jake Hall

13. Birthplace _____ Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hall

15. Birthplace _____ Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant _____ **(b) Address** 2601 N Whittier

17. (a) Place of burial or cremation _____ **(b) Date thereof** _____
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ **(b) Address** _____

19. (a) (Date received local registrar) FEB 29 1944 **(Registrar's signature)** J. J. Blum

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31
year 1944 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from December 16, 1943 to January 31, 1944
that I last saw her alive on January 31, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene of Labia Majora Unknown
Ischioirectal Abscess - non tuberc
Due to - cancer
123.3

Other conditions Congenital Malformations of Limbs
Mental Deficiency
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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? _____

23. Signature _____ **(M. D. or other)** _____
Address 2601 N Whittier St **Date signed** 2-2-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

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.