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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5750

FILED MAR 1 1944 318 1003

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 1674

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:
1602 North 14th Street, /
(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: 000 12 926

(a) State Missouri (b) County .....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1602 North 14th St.,
(If rural, give location)

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

3. (a) PRINT FULL NAME Lillie Sinclair

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex female

5. Color or race white

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 February 15th 1884
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 4 If less than one day ..... hr. ..... min.

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

10. Usual occupation Worked in Linen Room

11. Industry or business City Hospital # 1

FATHER
12. Name William Moore
13. Birthplace Missouri 0 (City, town or county) (State or foreign country)

MOTHER
14. Maiden name (unknown)
15. Birthplace Missouri 0 (City, town, or county) (State or foreign country)

16. (a) Informant Mr. William Swinhart
(b) Address 1602 North 14th St.,

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 2-21-44 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue

19. (a) FEB 20 1944 (Date received local registrar) (b) J. T. Bruck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19th year 1944 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from February 14, 1944, to February 18, 1944; that I last saw her alive on February 18, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombus	5 min.
Due to Myocarditis	2 month
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None!
Of autopsy None

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 Eric Simpson (M. D. or other) M.D.
Address 3739 Gravois Date signed 2/19/44

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(Licensed Embalmer's Statement on Reverse Side)

Dr. Eber Simpson
3739 Gravois Ave.,
La. 4088

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 Albert Mayfield

Licensed Embalmer No. 3077

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.