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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 28 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8182

Registration District No. 317 Primary Registration District No. 3064 Registrar's No. 478

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Ferguson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 118 S. Clay Ave.
(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: 42 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Louis

(c) City or town: Ferguson
(If outside city or town limits, write "RURAL")

(d) Street No.: 118 S. Clay Avenue
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Jane F. Atwood

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: Married

6. (b) Name of husband or wife: Le Grand L. Atwood 6. (c) Age of husband or wife if alive: 71 years

7. Birth date of deceased: 4 (Month) 12 (Day) 1874 (Year)

8. AGE: Years 69 Months 10 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace: Winchester (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: ____

FATHER
12. Name: George M. Fishback
13. Birthplace: Versales (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Katherine C. Railey
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Mr. Le Grand Atwood
(b) Address: 118 S. Clay Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-23-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Fee Fee Cemetery

18. (a) Signature of funeral director: Alexander Sons Inc
(b) Address: 6175 Delmar Blvd.

19. (a) FEB 24 1944 (Date received local registrar) (b) E. G. McGauran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2-21-44 day 21 year 1944 hour 2:15 minute ____ M.

21. I hereby certify that I attended the deceased from 12 years, 19__, to ____, 19__; that I last saw her alive on 2-21, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia (Bronchial)	
Due to: Acute Respiratory Infection	
Due to:	
Other conditions: Parkinsons Disease (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ____
Of autopsy: 109

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: 0

23. Signature: Ed W. Barsch (M. D. or other) MD
Address: 4566 Olive St Date signed: 4/22/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. C. W. Bassett
4500 Olive -
To 3800 - 2:15 to 6 P.M.

MAY 17 1944

MAR 16 1944

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 Jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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.