

S. No. 2
M-2-43
7-17-39
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8423

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 6 1944
Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 515

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 116 days
(Specify whether
In this community 8 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 449 Antelope
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lelia Mae Walker
3. (b) If veteran, name war ---
3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced, Separated
6. (b) Name of husband or wife Sanders Gates 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased: 6 (Month) 14 (Day) 1909 (Year)

8. AGE: Years 34 Months 8 Days 4 If less than one day hr. min.

9. Birthplace Starkville Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business ---

MOTHER FATHER { 12. Name James Campbell
13. Birthplace Starkville Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Anna Pope

15. Birthplace Starkville Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Koch Hosp. Records

(b) Address Koch, Hosp, Koch, Mo.

17. (a) Burial (b) Date thereof 2/24/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Charles G. Gates

(b) Address 4107 Finney Avenue

19. (a) 2-24-1944 (b) E. J. McBaran
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 18
year 44 hour 11 minute 30 PM. M.
21. I hereby certify that I attended the deceased from 10-22-43
1943 to 2-18-44 1944
that I last saw her alive on 2-18-44 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
Pulmonary Hemorrhage
Due to Pulmonary tuberculosis 9 mo.?

Due to _____
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 134
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 0

23. Signature Burnell Fredman (M. D. or other) MD
Address Koch Hosp, Koch, Mo Date signed 2-19-44

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

96
0
0

STATEMENT BY LICENSED EMBALMER

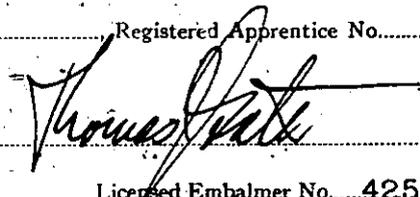
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No.....4259.....

P. O. Address.....4107 Finney Avenue.....

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.