

FILED JUN 1 1944 318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **4835**

1. PLACE OF DEATH:

(a) County **ST. Louis MO.**
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Isolation Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4/6/44-5/20/44**
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME **Nellie Vann**

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

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

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

7. Birth date of deceased **August 11 1910**
 (Month) (Day) (Year)

8. AGE: Years **33** Months **9** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **Mississippi** (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Andrew Phillips**
 13. Birthplace **Mississippi** (City, town, or county) (State or foreign country)
 14. Maiden name **Pearly James**
 15. Birthplace **Mississippi** (City, town, or county) (State or foreign country)

16. (a) Informant **Violet Becktame**
 (b) Address **5600 Arsenal**

17. (a) **Removal** (b) Date thereof **5-26-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wilson Ark**

18. (a) Signature of funeral director **J. F. Becktame & Son**
 (b) Address **3133 Bell Ave**

19. (a) **MAY 20 1944** (b) **J. F. Becktame** (Registrar's signature)
 (Date received local report) (Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**
 (c) City or town **ST. Louis MO.** **591**
 (If outside city or town limits, write "RURAL")
 (d) Street No **3016 Franklin** (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **20** 19**44**
 year **1944** hour **7** minute **22** P.M.

21. I hereby certify that I attended the deceased from **4/6/44** to **5/20 1944**
 that I last saw her alive on **MAY 20 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis far advanced**

Due to _____
 Due to _____

Other conditions (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?

While at work? _____ (Specify type of place) Means of injury _____

23. Signature **W. Klingberg** (M. D. or other) _____
 Address **Isolation Hosp** Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

OCT 22 1946

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Nellie Vann

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 33 Months 9 Days _____ (Unless than one day) _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address JUN 6 1944

19. (a) _____ (b) J. A. Brudeck (Registrar's signature)

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1944 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

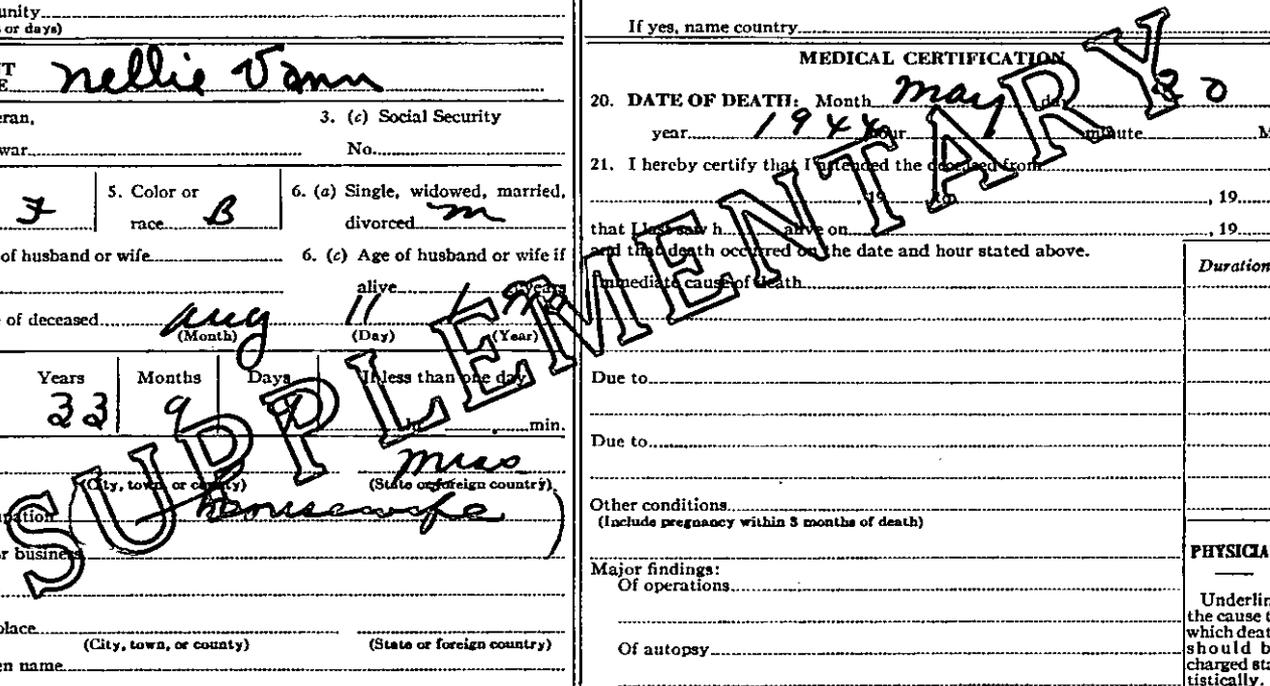
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(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 _____

23. Signature _____ (M. D. or other) _____

Date signed _____



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

6930

10834