

FILED OCT 13 1944 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 13 days  
(Specify whether)  
 In this community 20 years  
years, months or days

3. (a) PRINT, FULL NAME Josephine Dobson

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex female 5. Color or race Colored 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife Hosea DOBSON 6. (c) Age of husband or wife if alive 37 years  
 7. Birth date of deceased MARCH 16 1887  
(Month) (Day) (Year)

8. AGE: Years 57 Months 6 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business NONE

MOTHER FATHER  
 12. Name JOSIAH JONES  
 13. Birthplace ARKANSAS  
(City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN  
 15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Hosea DOBSON  
 (b) Address 3696 Finney Ave  
 17. (a) BURIAL (b) Date thereof 10-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation WASHINGTON PARK CEM.

18. (a) Signature of funeral director Boyd Bros. Funeral Home  
 (b) Address 3704 1/2 Finney Ave  
 19. (a) OCT 5 1944 (b) J. J. Brechee  
(Date received local registrar) (Registrar's signature)

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. 3696 Finney Avenue  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1,  
 year 1944 hour \_\_\_\_\_ minute 50 P. M.

21. I hereby certify that I attended the deceased from September 18, 1944 to October 1, 1944;  
 that I last saw h. or alive on October 1, 1944;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration Terminal  
 Due to Arteriosclerotic Heart Disease Unk.

Due to \_\_\_\_\_  
 Other conditions 9/24  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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) (e) Means of injury  
 23. Signature A. M. Mitchell (M. D. or other) \_\_\_\_\_  
 Address Bo. W. H. H. H. Date signed 10/1/44

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.....  
William C. McDowell....., Registered Apprentice No.....  
working under my personal supervision.

Signed, William C. McDowell  
Licensed Embalmer No. 2119

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.