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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 20 1944
3 18

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29401
State File No. _____
Registrar's No. 7914

Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(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 9 days
In this community 8 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lillie Harrell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Jacob 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased July 9th 1901
(Month) (Day) (Year)

8. AGE: Years 43 Months 2 Days 3
If less than one day hr. _____ min. _____

9. Birthplace Lunenburg Co Va
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Rubin Henry Stokes
13. Birthplace Lunenburg Va
(City, town, or county) (State or foreign country)
14. Maiden name Delina Ann
15. Birthplace Lunenburg Va
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob G Harrell
(b) Address 3132 Bell ave

17. (a) Removal (b) Date thereof 9-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baltimore Md

18. (a) Signature of funeral director JH Handleman
(b) Address 3133 Bell ave

19. (a) SEP 14 1944 (b) J. F. Bredet
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Bell
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 3122 Bell
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 12,
year 1944 hour 6 minute 35 A.M.
21. I hereby certify that I attended the deceased from September 3,
1944, to September 12, 19 44
that I last saw her alive on September 12, 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death
Rheumatic Heart Disease with Cardiac
Decompensation and Auricular Fibrillation
Due to _____

Due to 95-6
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)
(e) Means of injury _____

23. Signature Alva M. ... (M. D. or other)
Address 6601 W. Bell Date signed 9/13/44

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

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

J. J. Watson

Licensed Embalmer No. *2498*

P. O. Address *2769 Charlotte*

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.