V. S. No. 2
0M—8-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1003

State File No. 32076

Registration District No. 818

Primary Registration District No.

Registrar's No. 9114

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:
Isolation Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5-12-44-10-24-44 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 11

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3852 Evans
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mazola Boyce

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 3

5. Color or race Color

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 3 (Month) 27 (Day) 20 (Year)

8. AGE: Years 24 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Collinsville (City, town, or county) Tenn. 1 (State or foreign country)

10. Usual occupation Maid

11. Industry or business

FATHER
12. Name Jeff Boyce
13. Birthplace Collinsville (City, town, or county) Tenn. 1 (State or foreign country)

MOTHER
14. Maiden name Tressie Freeman
15. Birthplace Collinsville (City, town, or county) Tenn. 1 (State or foreign country)

16. (a) Informant Edythe Harris
(b) Address Isolation Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/44 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director F. A. Green
(b) Address 2915 Franklin ave.

19. (a) OCT 26 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24
year 1944 hour 9 minute 50 AM.

21. I hereby certify that I attended the deceased from 5-12-44, 19, to 10-24-44, 19;
that I last saw her alive on 10-24-44, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis 11

Due to

Due to 13

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy as above

Duration

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

23. Signature R W Maxwell (M. D. or other) 0

Address 5600 Arsenal Date signed 10-24

(Licensed Embalmer's Statement on Reverse Side)

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 G. A. Horn

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin ave

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.