

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32375

State File No. \_\_\_\_\_

FILED NOV 1 1944  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 9083

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(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 40 Days  
(Specify whether \_\_\_\_\_)

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. 2220 Cole Street  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lolita Savannah Hearn  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 5  
year 44 hour 10 minute 20 p.M.  
21. I hereby certify that I attended the deceased from 7 - 25  
1944, to 9 - 5, 19 44  
that I last saw her alive on 9 - 5, 19 44  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased 7 - 25 - 44  
(Month) (Day) (Year)

Immediate cause of death Prematurity;  
Lobar Pneumonia  
Due to Unknown

8. AGE: Years \_\_\_\_\_ Months 10  
If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Unknown  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy As above

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Stern Hearn  
13. Birthplace Holly Springs Mississippi  
(City, town, or county) (State or foreign country)  
14. Maiden name Marguerite Robinson  
15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Duwall  
(b) Address 2601 N. Whittier Street

23. Signature M. S. Hinkle (M. D. or other)  
Address 2601 N. Whittier St. Date signed \_\_\_\_\_

17. (a) Burial (b) Date thereof OCT 26 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Place: burial or cremation CITY CEMETERY

(a) Signature of funeral director V. B. Hudson  
(b) Address City Health Dept  
19. (a) OCT 26 1944 (b) J. Stedman  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER, FATHER

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

---

**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 with the above constitutes grounds for revocation of license.)**

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