

FILED NOV 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32776

State File No.

9162

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(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 18 days
(Specify whether years, months or days) 40 years

3. (a) PRINT FULL NAME Elizabeth Sanders

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

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

6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive — years

7. Birth date of deceased February 1890
(Month) (Day) (Year)

8. AGE: Years 54 Months 8 Days —
If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

12. Name John Johnson

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

14. Maiden name Unknown

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

16. (a) Informant Ella M. Johnson

(b) Address 3637 Finney Ave.

17. (a) Burial (b) Date thereof Oct. 30, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Wright's Funeral Home.
(b) Address 3100 Easton Ave.

19. (a) OCT 28 1944 (Date received local registrar)
J. F. Bradeck (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. 3637 Finney
(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 25,
year 1944 hour 12 minute 45 A. M.

21. I hereby certify that I attended the deceased from October 7,
1944 to October 26, 1944
that I last saw her alive on October 25, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Suppurative Parotitis
Duration 18 days

Due to 115-2

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) (c) Means of injury

23. Signature W. J. Erwin (M. D. or other)
Address 260 W. 11th Date signed 10/26/44

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

MOTHER FATHER

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address. 1154 Bayard St

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.