S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 5 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 39662

Registrar's No. 11083

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Saint Mary Infirmart
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Seventeene Days (Specify whether years, months or days)

In this community Eleven Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County None

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

(d) Street No. 4140 Enright Avenue
(If rural, give location)

(e) Citizen of foreign country? None (Yes or No)

If yes, name country None

3. (a) PRINT FULL NAME Ineze Nelson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Hurbard Nelson

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased November (Month) 10 (Day) 1914 (Year)

8. AGE: Years 30 Months Days 13 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER

12. Name Charles Goodwin

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

14. Maiden name Isabella Lacy

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

16. (a) Informant Herbert Nelson

(b) Address 4140 Enright Ave.

17. (a) Removel (Burial, cremation, or removal) (b) Date thereof 12/ 28/1944 (Month) (Day) (Year)

(c) Place: burial or cremation Fordice Ark.

18. (a) Signature of funeral director Mary Wade

(b) Address 4208 Finney Avenue

19. (a) DEC 27 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23 year 1944 hour 9 minute 55 P.M.

21. I hereby certify that I attended the deceased from Dec 7, 1944 to Dec 23, 1944 that I last saw her alive on Dec 23 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured Ectopic preg. 5 days
Lobar Pneumonia 3 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Ruptured Ectopic

Of autopsy Lobar Pneumonia

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

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 L. Williams Schulter (M. D. or other) MD

Address 4503 Page Date signed 12-26-44

(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 Arthur L. Holliard

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.