

FILED JAN 15 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 5655

Registrar's No. 163

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Mount Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 156 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Gertrude Stevens McAfee

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 17 1922  
(Month) (Day) (Year)

8. AGE: Years 22 Months 3 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name Decson B. Stevens

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

14. Maiden name Ettie Mae Givens

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

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San., Mount Vernon, Mo.

17. (a) Burial (b) Date thereof 12-12-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director A.P. Richardson

(b) Address 2625 Glasgow Ave

19. (a) 12-20-44 (b) Audy Crawford  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis County  
(c) City or town Wellston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6219 Suburban  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9  
year 1944 hour 11 minute 00 A. M.

21. I hereby certify that I attended the deceased from July 7, 1944, to Dec. 9, 1944,  
that I last saw her alive on Dec. 9, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration About 1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature A. J. Stine (M. D. or other) \_\_\_\_\_

Address State Sanatorium Date signed 12-9-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,  
District File Number 143-80

Date Filed JAN 12 1945

JAN 17 1945

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

*A. P. Richardson*

Licensed Embalmer No. *2928*

P. O. Address *St. Germain's 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.