

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **815**

Registration District No. **318**

Primary Registration District No. **1003**

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 **11 days**
(Specify whether
In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County _____
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3122 Pine**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Leora Love**
3. (b) If veteran, name war **no** **3. (c) Social Security** No. _____

4. Sex **Female** **5. Color or** race **Col.**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Albert Love** **6. (c) Age of husband or wife if** alive **37** years
7. Birth date of deceased. **Oct. 19, 1916.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
28 **3** **5** _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Toney Wallace.**
13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Callie Bennett**
15. Birthplace **Hickman Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert Love.**
(b) Address **3120 R. Pine St.**

17. (a) Burial (b) Date thereof **Jan. 30, 1945.**
(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) JAN 26 1945 (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **January** day **24**
year **1945** hour **6** minute **15** P.M.
21. I hereby certify that I attended the deceased from
January 13, 1945, to January 24, 1945;
that I last saw her alive on **January 24, 1945;**
and that death occurred on the date and hour stated above.

Immediate cause of death
Malignant Hypertension
Chr Glomerule-Nephritis
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration
Unk
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Alva Moore** (M. D. or other)
Address **2601 N Whittier St** Date signed **1-25-45**

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.*

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.