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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4197

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 1630

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: 2734 Mills St 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000 17

(c) City or town St Louis 9 21 (If outside city or town limits, write "RURAL")

(d) Street No. 2734 Mills St (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Sophia Everson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 2

5. Color or race Black

6. (a) Single, widowed, married, divorced Single 8

6. (b) Name of husband or wife

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

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

8. AGE: Years 55 Months Days If less than one day hr. min.

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

10. Usual occupation Housewood

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Thomas F. Callaway

(b) Address 1300 Clark

17. (a) (Burial, cremation, or removal) (b) Date thereof 2-19-45 (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson Barracks, Mo.

18. (a) Signature of funeral director A. L. Odom

(b) Address 1721 Franklin Ave. Rotary 8

19. (a) FEB 19 1945 (Date received local registrar) (b) J. F. Brideck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28 year 1945 hour 4 minute 50 P.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia Primary	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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? (Specify type of place)

While at work? (e) Means of injury 3

23. Signature Alfred J. Perry (M. D. or other)

Address Deputy Coroner Date signed: 2/9/45

(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 Washington University School of Medicine —, Registered Apprentice No. ——, working under my personal supervision.

Signed Dr. N. M. Schoenwater
Dey Local Anatomical Board
Licensed Embalmer No.
P. O. Address 1407 So Grand.

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.