

S. No. 2
DM-5-43
v. 5-17-39
X 36671

4350

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 16 1945

Registration District No. 318

Primary Registration District No. 100

Registrar's No. 1147

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

1. PLACE OF DEATH:
 (a) County ST LOUIS
 (b) City or town ST LOUIS, MO.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
NOMER G. PHILLIPS Hosp.?
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 DA. (Specify whether
 In this community 6 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County JEFFERSON
 (c) City or town FESTUS, MO. JD
 (If outside city or town limits, write "RURAL")
 (d) Street No. 549 So. ADAMS, Ste. 3 NR1
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME LILLIE HENDERSON
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 3rd.
 year 1945 hour 10: minute 30 P. M.
 February
 21. I hereby certify that I attended the deceased from
2, 1945, to February 3, 1945
 that I last saw her alive on February 3, 1945;
 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race COLORED
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife CLEMMIE HENDERSON
 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased JANUARY 8TH 1900
 (Month) (Day) (Year)

Immediate cause of death Ruptured appendix with peritonitis Duration 5 days

8. AGE: Years 55 Months 0 Days 25 If less than one day
 hr. _____ min. _____

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace TATE COUNTY MISS. 1
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE-WORK

11. Industry or business OWN-HOME

12. Name CHARLIE ROBINSON

13. Birthplace COLE-WATER MISS. 1
 (City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

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

16. (a) Informant Clemmie Henderson
 (b) Address Festus, Mo.

17. (a) Special Personal date thereof 2/5/1945
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation CRISTAL CITY, MO.

18. (a) Signature of funeral director Country R. Palitta
 (b) Address Cystal City, Mo.

19. (a) FEB 5 1945 (b) J. P. Baker
 (Date received local registrar) (Registrar's signature)

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 Alma Moore (M. D. or other) _____
 Address 2601 Whelan Date signed 2/5/45

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 Gentry C. Politte

Licensed Embalmer No. 3781

P. O. Address Crystal City, Mo

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.