

FILED MAR 28 1945

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
 (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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 days**
(Specify whether
 In this community **2 years**
years, months or days)

3. (a) PRINT FULL NAME **Bessie Arrington**

3. (b) If veteran, name war **none** **3. (c) Social Security No.** **none**

4. Sex **Female** **5. Color or race** **Negro** **6. (a) Single, widowed, married,** **divorced** **Widowed**
6. (b) Name of husband or wife. _____ **6. (c) Age of husband or wife if** _____
 alive _____ years

7. Birth date of deceased. **March 4, 1878**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
67	0	6	_____ hr. _____ min.

9. Birthplace **?** **Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

MOTHER FATHER

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Bessie White**

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

16. (a) Informant **Cherry Mae Buck**
(b) Address **2100 R. Franklin ave.**

17. (a) **shipped** **(b) Date thereof** **Mar. 16, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cannon Miss.**

18. (a) Signature of funeral director **Dement & Son**
(b) Address **2629-25 Cole Street**

19. (a) **MAR 16 1945** **(b)** **J. F. Bredack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **DAC**
 (c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2100 R. Franklin**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **10,**
 year **1945** hour **3** minute **45** A. M.

21. I hereby certify that I attended the deceased from **March 8,**
 19 **45** to **March 10,** 19 **45**
 that I last saw her alive on **March 10,** 19 **45**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Sub Arachnoid Hemorrhage**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 5 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 _____

23. Signature **B. F. Murphy** (M. D.)
Address **2601 N. White** Date signed **3/10/45**

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.....

W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address. *4575 Aldine*

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.