

S. No. 2
OM-5-43
v. 5-17-39
I X36671

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 23 1945
878

Registration District No.

Primary Registration District No. 1003

Registrar's No. 3199

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

006254
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1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution:
CITY HOSPITAL #1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 25 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
17

(c) City or town ST. LOUIS 7 21
(If outside city or town limits, write "RURAL")

(d) Street No. 2229A CHESTNUT
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EINORA POWELL

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 7 1945
year 1945 hour 1 minute 24 M.

4. Sex F 3 | 5. Color or race COL | 6. (a) Single, widowed, married, divorced WIDOW
9

6. (b) Name of husband or wife _____

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

7. Birth date of deceased DEC 27 1901
(Month) (Day) (Year)

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.

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>3</u>	<u>11</u>	_____ hr. _____ min.

Immediate cause of death _____
Meningococci Meningitis

Due to _____

Due to _____

9. Birthplace MEMPHIS TENN. 1
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

MOTHER FATHER {

12. Name UNKNOWN

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

14. Maiden name EINORA JOHNSON

15. Birthplace TENN. 1
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Emma Vaughn

(b) Address 2629a Chestnut st

17. (c) BURIAL (b) Date thereof Apr 11-45
(Burial, cremation, or removal) (Month) (Day) (Year)
National Cem

(c) Place: burial or cremation _____

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? _____

18. (a) Signature of funeral director J. W. Hughes

(b) Address 2620 LAWTON

19. (a) APR 10 1945 (b) J. F. Bedeak
(Date received local registrar) (Registrar's signature)

23. Signature Patrick E. Doyle (M. D. or other)
Date signed 4/14/45

(Licensed Embalmer's Statement on Reverse Side)

664

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.....

Clark Young

Licensed Embalmer No. *3371*

P. O. Address *St. Louis*

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.