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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11913

FILED MAY 3 1945

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3611

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hour (Specify whether
In this community 20 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17
(c) City or town St. Louis 9 11
(If outside city or town limits, write "RURAL")
(d) Street No. 3910 Finney Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah White

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex F. 3

5. Color or race Negro

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased 12 (Month) 25 (Day) 1901 (Year)

8. AGE: Years 43 Months 3 Days 25 If less than one day hr. min.

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

10. Usual occupation house work

11. Industry or business

MOTHER FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Naoma Oldham
(b) Address 3920 Fairfax

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Manuel
(b) Address 4659 Finney Ave.

19. (a) APR 24 1945 (Date received local registrar) (b) APR 24 1945 J. F. Biddeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1945 hour 6 minute 208 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: Cerebral Hemorrhage	
Due to: 83 yr	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

23. Signature [illegible] (M. D. or other) 3
Address [illegible] Date signed 4/27/45

(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 William C. McDowell, Registered Apprentice No. ....., working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

P. O. Address .....

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.