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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15064

FILED JUN 4 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4543

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 Phillips Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 2221a Franklin Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Carolyn Draper
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex F
5. Color or race Col
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 1 (Month) 6 (Day) 1942 (Year)

8. AGE: Years 3 Months 4 Days 15 If less than one day hr. min.

9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business Child
MOTHER FATHER
12. Name Lee Draper
13. Birthplace (City, town, or county) Iowa (State or foreign country)
14. Maiden name Grace Carter
15. Birthplace Mo (City, town, or county) (State or foreign country)
16. (a) Informant Carrie Brytony
(b) Address 3917 Madison St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem
18. (a) Signature of funeral director [illegible]
(b) Address 3517 Lackland Ave
19. (a) MAY 22 1945 (Date received by local registrar) (b) J. F. Budsch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st year 1945 hour 8 minute 30 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.

Immediate cause of death Cerebral Hemorrhage of brain, fracture of left femur, fracture of pelvis, multiple shock, Due to: Struck by a stolen Ford Driven by one Linda Potter Hurt at 2231 Franklin Ave. Around 3.40 P.M. May 20, 1945 — Duration

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

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) Accident
(b) Date of occurrence May 20, 1945
(c) Where did injury occur? St Louis (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Street (Specify type of place)
While at work? (e) Means of injury As above

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed 5/22/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 1173

P. O. Address 3517 Sochde Ave

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.