

15252

FILED JUN 9 1945

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 4858

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:  
Residence - 1850 23rd St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 mo. 1  
(Specify whether \_\_\_\_\_)  
In this community 27 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1850 23rd St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26  
year 1945 hour 12:55 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Aug  
1944 to May 26 1945  
that I last saw her alive on May 26 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Metastasis  
Due to Cancer of left breast Duration 9 months  
Due to \_\_\_\_\_  
Other conditions 50  
(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?

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. H. Bunge (M. D. or other) M.D.  
Address 2316 1/2 Market Date signed May 26 1945

3. (a) PRINT FULL NAME Cecilia Jones  
3. (b) If veteran, name war none 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Robt. Jones 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased Dec. 25 1897  
(Month) (Day) (Year)

8. AGE: Years 47 Months 5 Days 1  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Cairo, Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Luther Hilprecht  
13. Birthplace Keaton, Tenn.  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Salie Hilprecht  
15. Birthplace Columbus, Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robt. Jones

(b) Address 1850 23rd St.

17. (a) None (b) Date thereof 6-31-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cairo, Ill.

18. (a) Signature of funeral director William Parks

(b) Address 4506 Franklin  
19. (a) MAY 27 1945 (b) J. F. Brodeur  
(Date received local Registrar's) (Registrar's signature)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39  
SOM-5-1  
1 x1951

**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 my self, Registered Apprentice No. \_\_\_\_\_ working under my personal supervision.

Signed Amel A. Hanson  
Licensed Embalmer No. 3522  
P. O. Address 3506 Franklin

**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, above space should be left blank.**