

Registration District No. **318** Primary Registration District No. **L 1003** Registrar's No. **4156**

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

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town..... St. Louis, Missouri
(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 6 days
(Specify whether years, months or days)
 In this community..... 30 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County.....
 (c) City or town..... St. Louis,
(If outside city or town limits, write "RURAL")
 (d) Street No. 1334 Franklin
(If rural, give location)
 (e) Citizen of foreign country?..... 0 (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Julia Seymour
 (b) If veteran, name war..... No
 (c) Social Security No. No
 5. Color Female
 6. (a) COL
 (b) Name of husband or wife MORACEY
 (c) Age of husband or wife if alive 13
 7. Birth date of deceased 1886
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 6, year 1945 hour 7 minute 10 A. M.
 21. I hereby certify that I attended the deceased from April 30, 1945 to May 6, 1945
 that I last saw her alive on May 6, 1945
 and that death occurred on the date and hour stated above.
 Immediate cause of death Cerebral Hemorrhage
 Duration 6 days

8. AGE: Years 58 Months 9 Days 23 If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business.....

12. Name UNKNOWN

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

14. Maiden name " "

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

16. (a) Informant Lena Harris

(b) Address 909 1/2 N. 15th

17. (a) Burial (b) Date thereof 5-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Spaul Love

(b) Address 3103 Washington

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

Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

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) (c) Means of injury

23. Signature B. F. Murphy (M. D. or other)
 Address 2601 N. Webster Date signed 5/7/45

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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.....

H. Claude Gordon

Licensed Embalmer No.....

3489

P. O. Address.....

4575 Alder

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.