

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **1003**

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4**
4 (Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **May, Walter**
3. (b) If veteran, No. **No.** 3. (c) Social Security No. **No.**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Clarence** 6. (c) Age of husband or wife if alive **44** years
7. Birth date of deceased **Oct - 30 1889**
(Month) (Day) (Year)

8. AGE: Years **55** Months **6** Days **14** If less than one day hr. min.

9. Birthplace **Jasper Co. Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER

12. Name **J.C. Harvey**
13. Birthplace **Clay Co. Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Jennie Greenwood**
15. Birthplace **Clay Co. Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles E. Mercer**
Address **416 Madison**

17. (a) **Granite City** (b) Date thereof **5-14-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. John's Cem.**

18. (a) Signature of funeral director **Charles E. Mercer**
(b) Address **Granite City Illinois**

19. (a) **MAY 15 1945** (b) **J. F. Braduch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Madison**
(c) City or town **Granite City Illinois**
(If outside city or town limits, write "RURAL")
(d) Street No. **2415 Delmar**
(If rural, give location)
(e) Citizen of foreign country? **No** **2** (Yes or No)
If yes, name country **NR.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **14**
year **1945** hour **5** minute **35** M.
21. I hereby certify that I attended the deceased from **5-11-45** 19. to **5-14-45** 19.
that I last saw h. **alive** on **5/14-45** 19.
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Cecum**
Due to **Hb**
Due to **Hb**
Other conditions (Include pregnancy within 3 months of death)
Major findings: **Ascension R.L. 8**
Intestine to Cecum
Of autopsy

Duration
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 **7/07**
23. Signature **Rickardus** (M. D. or other) **7/07**
Address **4932 Mayland** Date signed **7/07**

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

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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. 2988

working under my personal supervision.

Signed

Charles E. Mercer

Licensed Embalmer No.

P. O. Address

Granite City, Ill

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.