

FILED JUL 14 1945 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 54837

Registration District No. 818 Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Mo.  
(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 18 days  
(Specify whether years, months or days)

In this community 23 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. 2625 Division  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel Black

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color ed race \_\_\_\_\_

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

6. (b) Name of husband or wife Everett Black

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased 11 (Month) 6 (Day) 1913 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>31</u>	<u>7</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

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

12. Name William Scott

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

14. Maiden name Victoria Jones

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

16. (a) Informant Ida Scott

(b) Address 2025 Division

17. (a) Burial (b) Date thereof 6-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK Dale

18. (a) Signature of funeral director Chas. V. B. Howell

(b) Address 2834 Bayville

19. (a) JUL 25 1945 (b) J. F. Bredeak  
(Date of death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20, year 1945 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from June 2, 1945 to June 20, 1945.

that I last saw her alive on June 20, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis (far advanced)

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? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

While at work? \_\_\_\_\_

23. Signature Alma Maske (M. D. or other) \_\_\_\_\_

Address 2600 Webster Date signed 6/22/45

Duration  
Unk.

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

*Chas. L. Howell*

Licensed Embalmer No. *2452*

P. O. Address

*2834 Gamble*

**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.**