S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

FILED AUG 3 1945

State File No. 22573

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6620

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 919 a N Ewing! (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 919 a N Ewing (If rural, give location) 11
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME IDA SINGLETON
3. (b) If veteran, name war IDA
3. (c) Social Security No.
4. Sex Female
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Arthur Singleton
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased Oct (Month) 15 (Day) 1891 (Year)

8. AGE:	Years	Months	Days	If less than one day
53	~~54~~	9	9	hr. min.

9. Birthplace (City, town, or county) Miss! (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Cleary
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Arthur Singleton
(b) Address 919 a N Ewing
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson Can
18. (a) Signature of funeral director J. A. Green
(b) Address 2910 Franklin ave
19. (a) JUL 28 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day July year 1945 hour 10 minute 30 P M.
21. I hereby certify that I attended the deceased from 4/1, 1945 to 7/25, 1945 that I last saw h. alive on , 19 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Due to
Due to Chronic Nephritis
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 131 a
Of autopsy No

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
23. Signature [signature] (M. D. or other)
Address 822 [illegible] Date signed 7/27/8

(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 J. A. Gilert

Licensed Embalmer No. 2963

P. O. Address 2910 Franklin 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.