S. No. 2
OM—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

24980

FILED AUG 11 1945

State File No.

Registration District No. 37

Primary Registration District No. 6076

Registrar's No. 1935

1. PLACE OF DEATH:

(a) County Rock

(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robt Rock Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 days (Specify whether

In this community 20 yrs? years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oc.

(c) City or town St Louis (If outside city or town limits, write "RURAL")

(d) Street No. 36 S. Channing (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Hattie Hatfield

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Fem 3

5. Color or race Col

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 2 (Month) 2 (Day) 1903 (Year)

8. AGE: Years 42 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Kentucky (City, town, or county) U.S.A. (State or foreign country)

10. Usual occupation Laundry Worker

11. Industry or business

FATHER
12. Name Harry Downer
13. Birthplace Kentucky (City, town, or county) U.S.A. (State or foreign country)

MOTHER
14. Maiden name Harriet Stokes
15. Birthplace Kentucky (City, town, or county) U.S.A. (State or foreign country)

16. (a) Informant Deceased

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-45 (Month) (Day) (Year)

(c) Place: burial or cremation Green Wood

18. (a) Signature of funeral director Bennie Cove

(b) Address 3103 Washington Blvd.

19. (a) 8-6-45 (Date received local registrar) (b) E. Gavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1945 hour 7 minute 25 P.M.

21. I hereby certify that I attended the deceased from 7-3-, 1945, to 7-31, 1945; that I last saw h alive on 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tbc. F.A.	2 yrs?
Due to	
Due to 13 b	
Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Samuel J. Kincaden (M. D. or other)

Address Rock Hosp. - Rock, MO Date signed 8/2/45

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(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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.