

S. No. 2
OM-5-43
v. 5-17-39
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26202

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 14 1945
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7897**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St Louis**
(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 **7 mo; 22 days**
(Specify whether)

In this community **30 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **COO**

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

(d) Street No. **3133a Thomas**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Mary Thomas**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** **3**

5. Color or race **Negro**

6. (a) Single, widowed, married, divorced. **2** **2**

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

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

7. Birth date of deceased **June 3, 1893**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	3	4	_____ hr. _____ min.

9. Birthplace **Cado, La.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Charles Stephenson**

13. Birthplace **Cado, La.**
(City, town, or county) (State or foreign country)

14. Maiden name **Emily Jackson**

15. Birthplace **Cado, La.**
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address **3133a Thomas**

17. (a) Burial **Burial** **(b) Date thereof** **9/10/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Father Dickson Cem.**

18. (a) Signature of funeral director **Russell Und. Co.**

(b) Address **2732 Pine Street**

19. (a) SEP 10 1945 **(b)** _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **7**
year **1945** hour **2:00** minute _____ A. M.

21. I hereby certify that I attended the deceased from
July 16, 1945, 19____, to **September 7, 1945**;
that I last saw her alive on **September 7, 1945**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**
Duration **Unk**

Due to _____

Due to _____

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? _____

While at work? _____ **(e) Means of injury:** _____

23. Signature **B J Murphy** (M. D. or other) _____

Address **2401 N. Whittier St** Date signed **9/7/45**

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

MOTHER FATHER

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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.
working under my personal supervision.

Signed Joel Russell
Licensed Embalmer No. 4112
P. O. Address Bl Lewis

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.