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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29350

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8310

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

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17
9
18

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: 1109 Ofallon st. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 2 mos - 20 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 600
(c) City or town St. Louis 17 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1109 Ofallon st. 1
(If rural, give location)
(e) Citizen of foreign country? Yes 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Wilmer Jean Rooks

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 — 0
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 2 (Day) 1945 (Year)

8. AGE: Years 0 Months 2 Days 20 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name Marcellus Rooks
13. Birthplace Crittendon Co. Ark. 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Josephine Knight
15. Birthplace Mississippi 1 (City, town, or county) (State or foreign country)

16. (a) Informant Marcellus Rooks
(b) Address 1109 Ofallon St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery
18. (a) Signature of funeral director Manuel
(b) Address 4059 Finney Ave.
19. (a) SEP 25 1945 (Date received local registrar) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22 year 1945 hour 5 minute 508 M.

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

Immediate cause of death Bronchus Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 107

Major findings:
Of operations
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

23. Signature Patrick E. Sayles 3 (M.D. or other)
Address Dayton Date signed 9/25/45

(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 James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 3704 Finney 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.