

FILED SEP 28 1945

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(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: **Peoples Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
In this community **9 months**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Bertha White**

3. (b) If veteran, name war **None**
3. (c) Social Security No. **488-30-757**

4. Sex **Female**
5. Color or race **Colored**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **T. C. White**
6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **April 2, 1913**
(Month) (Day) (Year)

8. AGE: Years **32** Months **5** Days **17**
If less than one day hr. min.

9. Birthplace **Tupelo, Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Folder in Laundry**

11. Industry or business **Superior Laundry**

12. Name **Eli Turner**

13. Birthplace **Mantachia, Miss.**
(City, town, or county) (State or foreign country)

14. Maiden name **Chaney Creighton**

15. Birthplace **Mantachia, Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. J. C. Whittle**

(b) Address **1112 1/2 Glasgow Ave.**

17. (a) **Removal** (b) Date thereof **Sept. 23, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **East St. Louis, Ill.**

18. (a) Signature of funeral director **C. J. Nash**

(b) Address **1112 1/2 Glasgow Ave.**

19. (a) **SEP 21 1945** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **None**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1412a Glasgow Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **19**
year **1945** hour **12:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Sept 12**, 1945 to **Sept 19**, 1945
that I last saw her alive on **Sept 19**, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized Peritonitis**

Due to **Pelvic abscess**

Due to **Infection**

Other conditions **139**
(Include pregnancy within 3 months of death)

Major findings: **Tubo-Ovarian Abscess**
Of operations **+ Pelvic abscess**
Of autopsy **no**

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

23. Signature **[Signature]** (M. D. or other)
Address **3136 Hawthorne** Date signed **9/21/45**

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

MOTHER FATHER

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 _____

Licensed Embalmer No. 2432

P. O. Address 11711 1/2 St

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.