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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31661

FILED NOV 10 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9473

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 HOSPT.
(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 MISSOUR (b) County
(c) City or town ST LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 712 N. 23rd ST.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

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3. (a) PRINT FULL NAME MERCEDES BARNES

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 3
5. Color or race C
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 6 (Month) 6 (Day) 1899 (Year)

8. AGE: Years 46 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Washington Co. (City, town, or county) Miss 1 (State or foreign country)
10. Usual occupation DOMESTIC
11. Industry or business

FATHER
12. Name JAMES SIMMONS
13. Birthplace VICKSBURG (City, town, or county) MISS. 1 (State or foreign country)

MOTHER
14. Maiden name SUSIE ROBINSON
15. Birthplace VICKSBURG (City, town, or county) MISS. 1 (State or foreign country)

16. (a) Informant Ernestine Littlejohn
(b) Address 2228 WASHINGTON AV.
17. (a) Bureal (Burial, cremation, or removal) (b) Date thereof 11-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation GREENWOOD CEM.
18. (a) Signature of funeral director A. F. Walton
(b) Address 2707 Stoddard St.
19. (a) NOV 2 1945 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 10 day 27 year 1945 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10/26 1945 to 10/27 1945 that I last saw her alive on 10/27 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration 2 or 3 yrs

Due to

Due to 93d

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy NO

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 [illegible] Date 10/3/45

(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 Arthur L. Holliard

Licensed Embalmer No. 4231

P. O. Address 1154 Bayard 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.