F. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34530

State File No.

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2552

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Louis County Hospital 6
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Chesterfield 0
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1, Box 1 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME ELIZABETH ANDERSON

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 Married 1

6. (b) Name of husband or wife Ardell Anderson

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased March (Month) 18 (Day) 1905 (Year)

8. AGE: Years 40 Months 7 Days 15 If less than one day hr. min.

9. Birthplace Chesterfield (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Hawkins.
13. Birthplace (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Priscilla Carter
15. Birthplace (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Elizabeth Anderson
(b) Address Chesterfield, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/ (Month) 7/ (Day) 45 (Year)
(c) Place: burial or cremation Chesterfield Mo.

18. (a) Signature of funeral director Missouri Md-co-
(b) Address 2631 Rosemble

19. (a) 11-6-45 (Date received local registrar) (b) E. G. McGavran MD (Registrar's signature) MSG

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day Third year 1945 hour Four minute 25 A.M.

21. I hereby certify that I attended the deceased from October 22nd 1945 to November 3rd 1945 that I last saw her alive on November 3rd 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism — Duration 5 hrs

Due to Incomplete abortion MD

Due to Exploratory Laparotomy on abdomen

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations At operation a pregnant uterus was found.
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 G. J. Murphy MD (M. D. or other)
Address 601 Brentwood Date signed 11/3/45

(Licensed Embalmer's Statement on Reverse Side)

DEC 7 1949

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: [illegible]

Licensed Embalmer No. 2963

P. O. Address: 2915 Franklin

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.