V. 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 DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35538

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10263

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: St. Marys Infirmary 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 1117
(If outside city or town limits, write "RURAL")

(d) Street No. 1036 N. Newstead 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Mattie Lee

3. (b) If veteran, name war ----

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louis Lee

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased March (Month) 25th (Day) 1905 (Year)

8. AGE: Years 40 | Months 7 | Days 29 | If less than one day ___ hr. ___ min.

9. Birthplace Port Gibson (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation Housewife

11. Industry or business -----

FATHER
12. Name Mathew Williams
13. Birthplace Clayborne Co. (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name Nancy Nixon
15. Birthplace Clayborn Co. (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant Louis Lee
(b) Address 1036 N. Newstead

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Blytheville, Ark.

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Ave.

19. (a) NOV 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24th year 1945 hour 10 minute A.M. M.

21. I hereby certify that I attended the deceased from October 10th, 1945 to November 24th, 1945 that I last saw her alive on November 24th, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypertensive Cardio Renal Disease	?
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 3136 Chouteau Ave. Date signed

(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

Thomas J. Gates, Registered Apprentice No.,

working under my personal supervision.

Signed

Licensed Embalmer No. 4259

P. O. Address 4107 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.