

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38606

Registration District No. 317 Primary Registration District No. 6076 State File No. 2795 Registrar's No. 2795

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent's Sanitarium 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 24 yrs. 11 months 3 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. L 96
(c) City or town St. Louis 300
(If outside city or town limits, write "RURAL")
(d) Street No. 7300 St. Charles, R.R 5
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MISS ANNA TALLULA ROY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 25 1876
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day Ninth year 1945 hour 4 minute 55 P.M.
21. I hereby certify that I attended the deceased from June 1936 to Dec. 9th 1945 that I last saw h.e. alive on December 7th 1945 and that death occurred on the date and hour stated above.
Immediate cause of death PNEUMONIA Duration 5 wks.

8. AGE: Years Months Days If less than one day
69 1 14 hr. _____ min. _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Winona (City, town, or county) MISS. 10 (State or foreign country)
10. Usual occupation At home
11. Industry or business A.
12. Name William Roy
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Anna Strong
15. Birthplace _____ (City, town, or county) (State or foreign country)
16. (a) Informant Miss Margaret
(b) Address 7300 St Charles R.R
17. (a) REMOVAL (b) Date thereof Dec 10 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation NEW ORLEANS
18. (a) Signature of funeral director C. M. Kelly
(b) Address 4386 Grand bl
19. (a) 12-11-45 (b) E. M. Duran
(Date received local registrar) (Registrar's signature)

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 P. E. Ketchum (M. D. or other) _____
Address 3700 Washington Date signed _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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. Lammers
Licensed Embalmer No. 4142
P. O. Address St. Louis

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10c

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2795

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Anno Tallula Ray

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____
(City, town, or county) (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec _____ Day _____
Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to bronchial pneumonia

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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature P. E. Kubitovick (M. D. or other) _____

Address _____ Date signed C

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

SUPPLEMENTARY

38006