

STANDARD CERTIFICATE OF DEATH

39471

State File No.

11044

FILED DEC 28 1945  
Registration District No. 318

Primary Registration District No.

1003

Registrar's No.

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 Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 days  
In this community Life Time (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4342 Finney  
(If rural, give location)  
(e) Citizen of foreign country? 11 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Rosa Lee McAdoo

3. (b) If veteran, name war none 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 Jonas McAdoo 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased August 29 1877  
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Willis Ray

13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Jonas McAdoo

(b) Address 4342 Finney Ave

17. (a) Burial (b) Date thereof 12/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakdale Cemetery

18. (a) Signature of funeral director C.W. Roberts

(b) Address 1416 No. Taylor ave

19. (a) DEC 19 1945 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16  
year 1945 hour 5 minute 6 A. M.

21. I hereby certify that I attended the deceased from 11-21, 1945, to 12-16, 1945, that I last saw her er alive on 12-16, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease with Decompensation

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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 O. L. Daniels (M. D. or other) \_\_\_\_\_

Address 2601 N. Wheeler Date signed 12/17/45

Duration

Unk

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Amiel Roberts, Registered Apprentice No. 387,  
working under my personal supervision.

Signed Walter E. Culkin

Licensed Embalmer No. 4198

P. O. Address 4912 Mountain 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.