

S. No. 2  
DOM-5-43  
Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **500**  
Registrar's No. **539**

**FILED** JAN 25 1946

Registration District No. **318** Primary Registration District No. **1003**

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  
6. Mo. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Gertrude Kidd  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race Col.  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Burgess Kidd  
6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased Sept. 5, 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 4 8  
.....hr. min.

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

10. Usual occupation Nil.

11. Industry or business WM. Petterson

12. Name.....  
13. Birthplace Miss.  
(City, town, or county) (State or foreign country)

14. Maiden name Charlett Patterson  
15. Birthplace Miss  
(City, town, or county) (State or foreign country)

16. (a) Informant James C. Waters

(b) Address 2903. a. Cass. Ave

17. (a) Burial (b) Date thereof Jan. 19. 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cent.

18. (a) Signature of funeral director J. J. Blodgett

(b) Address 2769 Chouteau

19. (a) JAN 17 1946 (Date received by local registrar)  
J. J. Blodgett (Registrar's signature)

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. 2903 A Cass  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 13  
year 1946 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from 12-20, 1945, to 1-13, 1946;  
that I last saw her alive on 1-13-46, 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease  
Duration Unk

Due to.....  
Due to.....

Other conditions (include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy Yes

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) (e) Means of injury.....  
23. Signature O. L. Daniels (M. D. or other)  
Address 2601 N. Colver Date signed 1/16

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

2700

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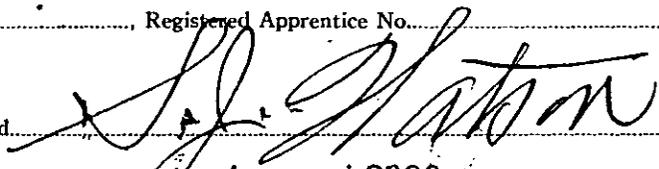
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STATEMENT BY LICENSED EMBALMER

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.....

  
.....  
Licensed Embalmer No. 2698

P. O. Address..... "2769 Chouteau. 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.