

2-1-5443  
5-17-39  
I X36671

**FILED FEB 31 1946**

Registration District No. .... Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County St. Louis

(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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Hrs.  
(Specify whether years, months or days)

In this community 25 yrs

3. (a) PRINT FULL NAME Bertha Todd

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

3. (c) Social Security No. 710

4. Sex Female

5. Color or race Col.

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

6. (b) Name of husband or wife John Todd

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased October 15 th. 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>3</u>	<u>14</u>	hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Willie Moore

13. Birthplace Unknown

14. Maiden name Lancy King

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

16. (a) Informant Corea Johnson

(b) Address 4065A West Bell

17. (a) Removal  
(Burial, cremation, or removal)

(b) Date thereof 1-31-46  
(Month) (Day) (Year)

(c) Place: burial or cremation E. Thomas Hill

18. (a) Signature of funeral director J. F. Bredek

(b) Address 3517 Laclede Avenue

19. (a) JAN 30 1946  
(Date received local registrar)

J. F. Bredek  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County St. Louis

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

(d) Street No. 2703 Bernard St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 28th.  
year 1946 hour 7 minute 20 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 Cerebral Apoplexy  
Right Lateral Ventricles

Duration

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

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

Other conditions 8-2  
(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 Patrick E. Taylor (M. D. or other) 3

Address Deputy Coroner Date signed 1-28-46

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.....

*Clark Young*

Licensed Embalmer No. *13371*

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. 7610  
Registrar's No. 1069

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(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 Bertha Todd  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife (John Todd) 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Oct 13 (Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) J. J. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 4  
(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 \_\_\_\_\_ Year 19 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

FEB 19 1940

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

3201

1018