

6.2
2-43
7-39
X35697

FILED MAR 28 1946

State File No. _____

Registration District No. _____

Primary Registration District No. 3070

Registrar's No. 560

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves

(c) Name of hospital or institution: 57 Lincoln Ave - 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 50 year (over) (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO - (b) County St. Louis 96

(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL") 4

(d) Street No. 57 Lincoln Ave 0
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Emma Givens

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

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

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

8. AGE: Years about 95 Months Days If less than one day hr. min.

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

10. Usual occupation nil

11. Industry or business _____

12. Name William Kennedy

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

14. Maiden name unknown

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

16. (a) Informant Mary James

(b) Address 57 Lincoln Ave

17. (a) Burial (b) Date thereof 3-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director J. C. Lewis

(b) Address 22 Euclid Webster Groves

19. (a) 3-6-1946 (b) E. S. McFarlan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3rd day March
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 2/15/46 to 3/3/46
that I last saw him alive on 3/3/46
and that death occurred on the date and hour stated above.

Immediate cause of death Ch. myocarditis

Due to Ch. endocarditis

Due to Senility 1316

Other conditions Ch. hypertens
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence no

(c) Where did injury occur? no
(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 J. C. Lewis (M. D. or other)
Address 22 Euclid Webster Groves Date signed 3/7/46

Duration

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 J. L. Lewis

Licensed Embalmer No. 2077

P. O. Address Whester Groves

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. April
560
Registrar's No. _____

Registration District No. 317 Primary Registration District No. 3070

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Webster Shore
(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) (Specify whether

3. (a) PRINT FULL NAME Emma Stevens
Lucas
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color of race B 6. (a) Single, widowed, married divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if /alive _____ years
7. Birth date of deceased not (Month) (Day) (Year)

8. AGE: Years 95 Months _____ Days _____ If less than one day hr. _____ min. mo

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 3-6-46 (Date received local registrar) (b) CS McManam (Registrar's signature) MSA

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 _____ day _____
year 1941 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 _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION

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

10679