

FILED APR 5 1946  
Registration District No. 318

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 2935

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 *0*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
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. 1325 Prairie  
(If rural, give location)

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

3. (a) PRINT FULL NAME Viola Cross

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22  
year 1946 hour 7 minute 36 P M.

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife Archie

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

7. Birth date of deceased Sept. 13 1902  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-1, 1946 to 3-22, 1946,  
that I last saw her alive on 3-22, 1946,  
and that death occurred on the date and hour stated above.

8. AGE: Years 43 Months 6 Days 9  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of Cervix  
Duration Unk

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

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

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

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

10. Usual occupation Domestic

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

Of autopsy No

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

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

MOTHER FATHER { 12. Name Ryas Forman

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

14. Maiden name Maggie Nelson

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

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? \_\_\_\_\_

16. (a) Informant Irene Turner

(b) Address 1046 N. Newstead Ave.

17. (a) Burial (b) Date thereof 3-28-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) Mar 28 (b) J. F. Brebeck  
(Date received from Registrar) (Registrar's signature)

23. Signature J. E. Caprley (M. D. or other) \_\_\_\_\_  
Address 2601 N. Louther Date signed 3/25/46

(Specify type of place) (e) Means of injury

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

95-10

**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.....

Thomas J. Gates

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 4259

P. O. Address. 4107 777

**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.**