

FILED

MAR 30 1946  
MAR 18 1946

## STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No.

2734

## 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 7 days  
 (Specify whether  
 In this community 10 years  
 years, months or days)

3. (a) PRINT FULL NAME John Ivory

3. (b) If veteran, name war no  
 3. (c) Social Security No. 489-16-9116

4. Sex male 5. Color or race negro  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Annæ  
 6. (c) Age of husband or wife if alive 48 years  
 7. Birth date of deceased Dec. 3 1897  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
48 3 14 hr. min.

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

10. Usual occupation Labor

11. Industry or business Work at coal yard

12. Name Peiro Ivory

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

14. Maiden name Malissie Lathen

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

16. (a) Informant Mrs. Ivory

(b) Address 3216 a Lawton

17. (a) burial (b) Date thereof 3/23/46  
 (Burial, cremation, or removal) (City or town) (County) (State) (Month) (Day) (Year)  
St. Louis, Mo

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director [Signature]

(b) Address 1721 Calver St

19. (a) MAR 22 1946 (b) J. J. Fredrick  
 (Date received by registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 009  
 (c) City or town St. Louis 21 17  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3216 Lawton  
 (If rural, give location) 9  
 (e) Citizen of foreign country? no (Yes or No) 0  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17  
 year 1946 hour 7 minute A M.

21. I hereby certify that I attended the deceased from 3-10 1946, to 3-17 1946,  
 that I last saw im alive on 3-17 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease with  
Decompensation Duration Unk

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)

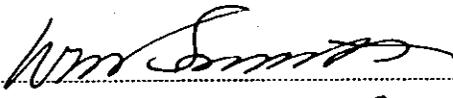
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature E. B. Williams (M. D. or other)  
 Address 2601 N. Whittier Date signed 3/19/46

OCT 11 1946

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. 4371  
P. O. Address. 1721 Coleman

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *2734*

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:  
  
(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..... *John Quary*  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... *m* 5. Color or race..... *B* 6. (a) Single, widowed, married, divorced..... *m*  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
7. Birth date of deceased..... *Dec 3*  
(Month) (Day) (Year)

8. AGE: Years..... *48* Months..... *3* Days..... If less than one day..... hr..... min.

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

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)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) *3-22-1946* (b) *J. F. Burdick*  
(Date received local registrar) (Signature)

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..... *April* 19.....  
year..... *1946* 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.  
in 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) (c) Means of injury.....

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

APR 5 1946

11025

OCT 11 1941