

5 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25743

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6564**

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

(d) Length of stay: In hospital or institution **12 days**
(Specify whether years, months or days)

In this community **2 yrs**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mattie Solomon**

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 **widowed**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **7 7 1881**
(Month) (Day) (Year)

8. AGE

Years	Months	Days	If less than one day
64	?	?	hr. min.

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

10. Usual occupation **Retired**

MOTHER FATHER

11. Industry or business _____

12. Name **Alex Owens**

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

14. Maiden name **Ellie Owens**

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

16. (a) Informant **Jessie Lee Moore**

(b) Address **2818 Dickson St.**

17. (a) **Removal** (b) Date thereof **7/27/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sanatobia Miss.**

18. (a) Signature of funeral director **Ellis Funeral Home**

(b) Address **2820 Stoddard St.**

19. (a) **JUL 26 1946** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____

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

(d) Street No. **2818 Dickson**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
year **1946** hour **4** minute **45** PM.

21. I hereby certify that I attended the deceased from **July 12**, 19 **46** to **July 24**, 19 **46**
that I last saw h. **or** alive on **July 24**, 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Multiple Cerebral Hemorrhages** Duration **Unk**

Due to _____

Due to _____

Other conditions (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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **L. J. Suman** (M. D. _____)

Address **2601 N Whittier** Date signed **7-25-46**

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

F. Boyer

....., Registered Apprentice No.

.....
working under my personal supervision.

Signed

Fornie Boyer

Licensed Embalmer No.

2946

P. O. Address

St Louis mo

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.