

V. S. No. 2
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Rev. 5-17-39
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28942

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 29 1946
318

1003

Registrar's No. 2243

Registration District No. _____ Primary Registration District No. _____

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:
St. Mary's Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days)

In this community Life

3. (a) PRINT FULL NAME STANTON PAGE

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

3. (c) Social Security No. --

4. Sex Male 2. Color or race Negro

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

6. (b) Name of husband or wife Ruth

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased: Jan. 1 1899
(Month) (Day) (Year)

8. AGE: years months days
47 7 21
hr. min.

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

10. Usual occupation Waiter

11. Industry or business --

MOTHER FATHER

12. Name Thomas Page

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

14. Maiden name Labosca Stanton

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

16. (a) Informant Ruth Page
(b) Address 6315 Colorado Ave.

17. (a) Burial (b) Date thereof 8-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director Chas. J. Gates
4107 Finney Ave.

(b) Address _____

19. (a) AUG 23 1946 (b) J. F. Bredek
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0000

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

(d) Street No. 6315 Colorado Ave.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22nd
year 1946 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from Aug
9 1946 to Aug. 26 1946
that I last saw him alive on Aug. 22 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 5 years

Due to Myocardial infarction - 5 years
vascular disease

Due to _____

Other conditions 93
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Uremia Pyelonephritis
Non-calculous

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 5 rd.

23. Signature Am Jackson (M. D. or other) MD
Address 1536 Papin St. Date signed 8/22/46

(Licensed Embalmer's Statement on Reverse Side)

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

03442
27780

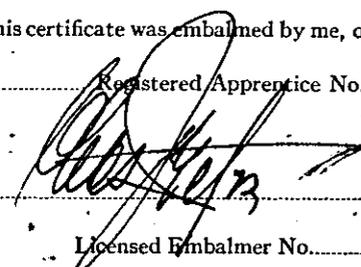
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Chas. J. Gates

Registered Apprentice No.....

working under my personal supervision.

Signed.....


Licensed Embalmer No..... **1825**

P. O. Address..... **4107 Finney Ave.**

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.