

S. No. 2
 DM-5-43
 v. 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 28976
 Registrar's No. 7383

FILED SEP 9 1946
 Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (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 6 days
(Specify whether years, months or days)
 In this community 20 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County oao
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL") 2517
 (d) Street No. 1113 Carr
(If rural, give location) 9
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Ivery Pruitt
 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 -- 9
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Unavailable 1891
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 23
 year 1946 hour 12 minute 35 A. M.
 21. I hereby certify that I attended the deceased from Aug. 17, 19 46 to Aug. 23, 19 46
 that I last saw her alive on August 23, 19 46
 and that death occurred on the date and hour stated above.

8. AGE: Years About 55 Months _____ Days _____ If less than one day hr. _____ min. _____

Immediate cause of death Hypertensive Cardiovascular Disease with Decompensation Undet
 Duration _____
 Due to _____
 Due to _____
 Other conditions None
(Include pregnancy within 3 months of death)

9. Birthplace Houston Texas
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife
 11. Industry or business --
 12. Name Unavailable
 13. Birthplace " 9
(City, town, or county) (State or foreign country)
 14. Maiden name "
 15. Birthplace " 11
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Major findings: _____
 Of operations _____
 Of autopsy None

16. (a) Informant Everett Twine
 (b) Address 1113 Carr St.
 17. (a) Burial (b) Date thereof 8-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood Cemetery
 18. (a) Signature of funeral director Chas. J. Gates
 (b) Address AUG 26 1946 Finney Ave.
 19. (a) _____ (b) J. J. Brasher
(Data received local registrar) (Registrar's signature)

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 E. B. Williams M. D. or other _____
 Address 2601 N. White Date signed 8/24/46

STATEMENT BY LICENSED EMBALMER

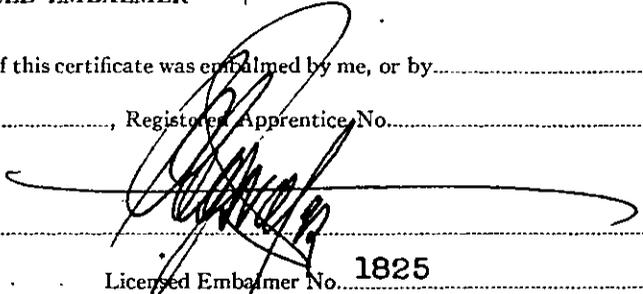
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

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.