

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

34963

State File No. _____

Registrar's No. 8911

Registration District No. _____ Primary Registration District No. 1003

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. Louis City Hospital 0
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~8322 Alabama~~ 00
(b) County _____
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 8322 Alabama
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mollie Branch
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Richard Branch
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased Nov. 10 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 58 11 6 hr. _____ min.

9. Birthplace Illinois /
(City, town, or county) (State or foreign country)

10. Usual occupation Seamstress

11. Industry or business Carol-Kiel Garment Co.

12. Name Thillia Sellers

13. Birthplace Kansas /
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Illinois /
(City, town, or county) (State or foreign country)

16. (a) Informant Cecil Maye

(b) Address 8322 Alabama

17. (a) burial (b) Date thereof Oct. 18/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill cemetery

18. (a) Signature of funeral director Fendler Und. Co.

(b) Address 7420 Michigan Ave

19. (a) OCT 18 1946 (Date received local burial) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
year 1946 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Nemotomas left side
2. deceleration left lung. 3. subdural
hemorrhage of brain
Due to when she was struck by a
automobile being driven by
Anna Marie Danish in front
of 8312 Alabama around 7:10 P.M.
Nov 7 1946
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 170
Of operations _____
Of autopsy 170

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) Accident

(b) Date of occurrence Oct 15 1946

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Street

While at work? _____ (Specify type of place)
(e) Means of injury Car

23. Signature Thomas O. Callahan (M. D. or other) _____

Address Corona Date signed 10-19-46

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.....

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

working under my personal supervision.

Signed..... *Ernest W. Spillers*

Licensed Embalmer No..... *4080*

P. O. Address.....

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.

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1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town _____
 (c) Name of hospital or institution: St. Louis City Hospital
(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)

3. (a) PRINT FULL NAME Mollie Branch
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Richard 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased Nov 10 1898
(Month) (Day) (Year)

8. AGE: Years 47 Months 11 Days 6 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. J. Bredeck
(Date received local registrar) (Registrar's 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)
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20. DATE OF DEATH: Month Oct day 16
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

OCT 15 1945

34963