

No. 2  
-12-45  
5-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38583

FILED DEC 9 1946

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10032**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_

(b) City or town St Louis

(c) Name of hospital or institution: Homer Phillips Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 52 days (Specify whether \_\_\_\_\_)

In this community 4 years (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Osceola

(c) City or town St Louis (If outside city or town limits, write "RURAL") 1117

(d) Street No. 3958 Evans (If rural, give location) 7

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** EMMA FARMER

**3. (b) If veteran,** name war none

**3. (c) Social Security** No. none

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Nov. day 23  
year 1946 hour 3 minute 40 P. M.

**21. I hereby certify that I attended the deceased from** 10-1 19 46 to 11-23 19 46  
**that I last saw her** or **alive on** Nov. 23 19 46  
**and that death occurred on the date and hour stated above.**

**4. Sex** Female **5. Color or race** Negro

**6. (a) Single, widowed, married, divorced** Unmarried

**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** \_\_\_\_\_  
alive \_\_\_\_\_ years

**7. Birth date of deceased.** May 9 1893  
(Month) (Day) (Year)

**Immediate cause of death** General Paresis **Duration** Undet.

**Due to** \_\_\_\_\_

**Due to** \_\_\_\_\_

**Other conditions** None  
(Include pregnancy within 3 months of death)

**8. AGE:**

Years	Months	Days	If less than one day
<u>53</u>	<u>6</u>	<u>14</u>	hr. _____ min. _____

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

**10. Usual occupation** Handdresser

**Major findings:**

Of operations \_\_\_\_\_

Of autopsy No

**PHYSICIAN** \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**MOTHER FATHER**

**11. Industry or business** \_\_\_\_\_

**12. Name** unknown

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

**14. Maiden name** Sarah Matthews

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

**16. (a) Informant** Pearlythie Matthews

**(b) Address** 3958 Evans Ave

**17. (a) Removal** **(b) Date thereof** Nov 25 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Cypress Hill

**18. (a) Signature of funeral director** J. J. Vanhaese

**(b) Address** 2205 No. 1st St. St. Louis, Mo.

**19. (a) NOV 29 1946** **(b) J. J. Vanhaese**  
(Date 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? \_\_\_\_\_

**23. Signature** H. J. Egan **(M. D. or other)** 0  
Address 2601 N. Whittier Date signed 11/25/46

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

12/27/54

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 me  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Ben. H. Baldaris  
Licensed Embalmer No. 2420  
P. O. Address East St Louis Ill

**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.**