

S. No. 2
M-5-43
5-17-39
P I X36571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

339226

State File No. _____

FILED NOV 25 1946
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9536

1. PLACE OF DEATH:

(a) County _____

(b) City or town St Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark 23

(c) City or town Alexandria
(If outside city or town limits, write "RURAL") NR

(d) Street No. _____
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Oma Ray White

3. (b) If veteran, name war Nil

3. (c) Social Security 481-03-3602

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 3
year 46 hour 8 minute 40 P.M.

21. I hereby certify that I attended the deceased from 11-1-1946 to 11-3-1946
that I last saw him alive on 11-3-1946
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Marie White

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased September 13 1900
(Month) (Day) (Year)

Immediate cause of death Respiratory Failure

Due to 2 damaged respiratory 2 aspir. pneum. 1 cancer

Due to Intracranial tumor & operation therefor 1 yr.

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

8. AGE: Years Months Days If less than one day
46 1 20 hr. min.

Major findings: Brain tumor
Of operations Malignant

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Carpenter

MOTHER FATHER

11. Industry or business _____

12. Name Samuel White

13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Parson

15. Birthplace Unknown Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marie White

(b) Address Alexandria Missouri

17. (a) Burial (b) Date thereof 11-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashton, Missouri

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 _____

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 7 1946 J. F. Bredeek
(Date received local registrar's certificate) (Registrar's signature)

23. Signature Patricia J. Lanier (M. D. 10/3/46)
Address Barnes Hospital Date signed 10/3/46

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

380-1

AUG 11 1948

DEC 20 1946

NOV 13 1953

AUG 4 1954

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 Elmo R. Cadwell

Licensed Embalmer No. 4077

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.