

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

43  
39  
36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

**FILED DEC 23 1946** 318

**STANDARD CERTIFICATE OF DEATH** 1003

State File No. **42545**  
Registrar's No. **10864**

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 Days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1410a N. 21st  
(If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Earleen Ivory

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro 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 10 27 46  
(Month) (Day) (Year)

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name William Ivory

13. Birthplace Greenwood Mississippi  
(City, town, or county) (State or foreign country)

14. Maiden name Cora Mae Garrison

15. Birthplace Portland Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter M. Sheppard, R.R. 1

(b) Address 2601 N. Whittier

17. (a) Buried (b) Date thereof DEC 19 1946  
(Burial, cremation, or removal) (City or town) (County) (State) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson

(b) Address City Health Dept

19. (a) DEC 14 1946 (b) Registrar's signature J. F. Brudeck  
(Date received local registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 11 day 14 year 1946 hour 6 minute 00 A.M.

21. I hereby certify that I attended the deceased from 12:50 A.M. 10-27 to 6:00 A.M. 11-14, 1946, that I last saw her alive on 11-14, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

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 W. P. Sinker (M. XXXXX) 46

Address 2601 N. Whittier Date signed 12-13

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

---

---

**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.....

Licensed Embalmer No.....

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.**