

FILED JAN 13 1947
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State File No. _____
Registrar's No. 11347

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos
(Specify whether
In this community 4 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1349 Elliott
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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3. (a) PRINT FULL NAME Beatrice Jones
3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 29
year 1946 hour 6 minute 30 P./M.
21. I hereby certify that I attended the deceased from 10-28, 19 46 to 12-29, 19 46
that I last saw her alive on Dec. 29, 19 46
and that death occurred on the date and hour stated above.

4. Sex F. 3 5. Color or race Col. 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive years
7. Birth date of deceased MAR. 20 1910
(Month) (Day) (Year)

Immediate cause of death _____
Esophageal Cohesions; Dehydration and Malnutrition
Duration Undet.

8. AGE: Years Months Days 9 If less than one day
36 9 9 hr. min.

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

9. Birthplace OSCEOLA, ARK. 1.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK
11. Industry or business _____
12. Name JAMES GRAHAM
13. Birthplace NEW MADRID MO 0
(City, town, or county) (State or foreign country)
14. Maiden name LUCY SINGLETON
15. Birthplace BROWNVILLE TENN. 1
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy No
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Izzetta Wilson
(b) Address 1349 Elliott Ave
17. (a) BURIAL (b) Date thereof 1-2-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation GREENWOOD
18. (a) Signature of funeral director A. F. WALTON
(b) Address 2707 STODARD ST.
19. (a) JAN 2-47 (b) J. F. Braden
(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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. B. Williams (M. D. or other) _____
Address 2601 N Whittier Date signed 12/31/46

MOTHER FATHER

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 *Arthur L. Heilbard*

Licensed Embalmer No. *11221*

P. O. Address *1154 Bayard*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.