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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43654**  
Registrar's No. **11380**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(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 12/29 - 12-30-46  
(Specify whether  
In this community 2 Mos. 1 Day  
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. 2317 CLARK  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MICHAEL FORD  
3. (b) If veteran, name war 2  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Oct 29 1946  
(Month) (Day) (Year)

8. AGE: Years 0 Months 2 Days 1  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace. ST. LOUIS MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

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

12. Name RUBEN HILL 9

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

14. Maiden name CHARLENE FORD

15. Birthplace WARREN ARKANSAS  
(City, town, or county) (State or foreign country)

16. (a) Informant Charlene Ford

(b) Address 2317 CLARK

17. (a) Burial (b) Date thereof 1-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK Cem.

18. (a) Signature of funeral director Peoples UND. Co.  
(b) Address 3109 FRANKLIN AVE.  
JAN 3 1947

19. (a) \_\_\_\_\_ (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 12 day 30  
year 46 hour 5 minute 58 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 \_\_\_\_\_  
Duration \_\_\_\_\_

Probable Cerebral Embolism or Congenital

Due to Malformation - possibly of the Central Nervous System

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

Major findings: 157 d  
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 \_\_\_\_\_  
(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)  
(2) Means of injury \_\_\_\_\_  
23. Signature John E. Smyke (M.D. or other) \_\_\_\_\_  
Address 1117 1/2 Date signed 1/30/47

**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 *John J. Petrus*  
Licensed Embalmer No. *4184*  
P. O. Address *H. Lewis, Jr.*

**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.**