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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5968

FILED FEB 24 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1407

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: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 9 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 25000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1729a Franklin Ave. 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mrs Maggie Atkins

3. (b) If veteran, name war

3. (c) Social Security No. ~~Married~~

4. Sex F. 3

5. Color or race Col

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

6. (b) Name of husband or wife Reed Atkins

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased 4 (Month) 16 (Day) 1911 (Year)

8. AGE: Years 30 Months 8 Days 19 If less than one day hr. min.

9. Birthplace Martin (City, town, or county) Tenn (State or foreign country)

10. Usual occupation Made Work

11. Industry or business

FATHER
12. Name Buck Adams
13. Birthplace (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Phenia Simmons
15. Birthplace (City, town, or county) Tenn (State or foreign country)

16. (a) Informant R. D. Atkins
(b) Address 1729 A. Franklin Ave

17. (a) Removal By Rail (Burial, cremation, or removal) (b) Date thereof 2-9-47 (Month) (Day) (Year)
(c) Place: burial or cremation Fulton Ky

18. (a) Signature of funeral director Gus Lowe
(b) Address 2930 Dickson St.

19. (a) 2 11 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

FEB 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 5 year 1947 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from / , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

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?
(Specify type of place)

While at work? (e) Means of injury 3

23. Signature Dr A J Stern (M. D. or other)

Address Dyer Date signed 2/6/47

(Licensed Embalmer's Statement on Reverse Side)

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. Hellard

Licensed Embalmer No. 4321

P. O. Address 1154 Bayard ave.

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.