. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7459

State File No. 0

Registration District No. 317 Primary Registration District No. ~~3069~~ 6076 Registrar's No. 563

1. PLACE OF DEATH:

(a) County Koch

(b) City or town "Rural"
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robt Koch Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 659 days (Specify whether
In this community 20 years?
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-20

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

(d) Street No. 6668 Delmar 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country —

3. (a) PRINT FULL NAME Eddie Mae Ray

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Fem 3

5. Color or race Col

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife —

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

7. Birth date of deceased 10 (Month) 27 (Day) 03 (Year)

8. AGE: Years 43 Months 4 Days 12 If less than one day hr. min.

9. Birthplace Grenada (City, town, or county) Miss 1 (State or foreign country)

10. Usual occupation Maid

11. Industry or business

FATHER
12. Name Robert Jolliff
13. Birthplace (City, town, or county) Miss 1 (State or foreign country)

MOTHER
14. Maiden name Nellie Ingram
15. Birthplace (City, town, or county) Miss 1 (State or foreign country)

16. (a) Informant Record of St.

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (Month) (Day) (Year)

(c) Place: burial or cremation ~~St. Peter's Cemetery~~

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) 3-14-47 (Date received local registrar) (b) Ruth Jollen MD (Registrar's signature) MSC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 11 year 1947 hour 8 minute 55 A.M.

21. I hereby certify that I attended the deceased from 5-21, 1946, to 3-11, 1947, that I last saw her alive on 3-11, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tbc FA	19 yrs?
Due to 13 b	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 0

23. Signature Bernard Friedman (M. D. or other) M.D.

Address Robt Koch Hosp. Koch Mo Date signed 3/14/47

(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 John Cunningham, Registered Apprentice No. 452, working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 1825

P. O. Address 4107 Finney 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.