

No. 2
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5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 8 1947
Registration District No. **398**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

10674
State File No. _____
Registrar's No. **3213**

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution:
St. Mary's Infirmary
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(d) Street No. 401a S. Garrison
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Mary Cole
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 _____
6. (b) Name of husband or wife Henry Cole 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 91 hr. min.

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

10. Usual occupation Nil

11. Industry or business _____
12. Name James Cole
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

MOTHER FATHER

16. (a) Informant Ada Callus
(b) Address 401a S. Garrison
17. (a) Burial (b) Date thereof 3/27/47
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Russell Und., Co.
(b) Address 2732 Pine Street
19. (a) MAR 26 1947 (b) J. F. Burkhead
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 23rd
year 1947 hour 12 minute 45 A.M.
21. I hereby certify that I attended the deceased from 3-21
1947 to 3-22 1947
that I last saw her alive on 3-22 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Lobar Pneumonia Duration 2 days
Uremia 2 days
Due to _____
Due to 108
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Edwin A. Lee (M. D. or other) MD
Address 1536 Papin St. Date signed 3/25/47

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

Clark Young

Licensed Embalmer No.

3371

P. O. Address

St Louis 6

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.