

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10944**
Registrar's No. **2534**

Registration District No. **312** Primary Registration District No. **100**

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.....
1 mo. 13 days (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Lillie Harris**
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 **Married**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Dec. 24 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 2 11 hr. min.

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

10. Usual occupation **Domestic**

11. Industry or business.....

12. Name **Unknown**

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

14. Maiden name **Lena Robinson**
(City, town, or county) (State or foreign country)

15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lillie Harris (deceased)**
(b) Address **2106 Randolph**

17. (a) **Removal** (b) Date thereof **3/11/47**
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director **W.H. Green**
(b) Address **St. Louis, Mo**

19. (a) **MAR 11 1947** (b) **J.F. Bredner**
(Date received local registrar) (Registrar's signature)

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. **2106 Randolph**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **5**
year **1947** hour **3** minute **5 P** M.

21. I hereby certify that I attended the deceased from
8-19 19**46** to **Mar. 5** 19**47**
that I last saw her alive on **Mar. 5,** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Ovary with Generalized Metastasis**
Duration **Undet.**

Due to.....

Due to.....

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy..... **No**

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 **Clifford G. Hancock** (M. D. or other).....

Address **2601 N Whittier** Date signed **3/16/47**

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

MOTHER FATHER

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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.

Signature

M. E. Green

Licensed Embalmer No.

1173

P. O. Address

1318 E. Broadway

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.