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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11441

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2797

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: 910 O'Fallon
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 18 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 060
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 910 O'Fallon 259
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Susan Rhodes

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 2

5. Color or race Negro

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 Oct. (Month) 13 (Day) 1844 (Year)

8. AGE: Years 102 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Raleigh (City, town, or county) N. Carolina (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Lot Davis
13. Birthplace N. Carolina (City, town, or county) (State or foreign country)

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

16. (a) Informant James Rhodes
(b) Address 910 O'Fallon

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Dement & Son
(b) Address 2629-31 Cole Street

19. (a) MAR 17 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13 year 1947 hour 1 P.M. minute ****M.

21. I hereby certify that I attended the deceased from 3/10/47 1947 to March 13, 1947; that I last saw her alive on March 12, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis — Duration 3 days
Infirmities of Old Age

Due to Infirmities of Old age

Due to

Other conditions None
(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

23. Signature J. Davis (M. D. or other) M.D.
Address 274 Franklin Ave 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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.