

No. 2
12-45
17-39
X47070

FILED APR 8 1948

Registration District No.

Primary Registration District No. **1003**

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 **19 days**
(Specify whether)

In this community
years, months or days)

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. **4319 Washington**
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Beatrice Shields**

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

7. Birth date of deceased **April 28 1915**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **22**
year **1947** hour **9** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **3-3**, 19**47**, to **3-22**, 19**47**.
that I last saw h.er alive on **Mar. 22**, 19**47**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia; Bstulo-in-Ano**

8. AGE: Years Months Days If less than one day

31 10 24 hr. /min.

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

10. Usual occupation **Domestic**

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

MOTHER FATHER

11. Industry or business

12. Name **Charlie Yates**

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

14. Maiden name **H. Rice**

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

PHYSICIAN

Major findings:
Of operations
Of autopsy **No**

Underline the cause to which death should be charged statistically.

16. (a) Informant **Patient**

(b) Address **4488 Delmar Ave**

17. (a) **Removal** (b) Date thereof **3-26-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **S. Florio Ill**

18. (a) Signature of funeral director **P. Williams**

(b) Address **3517 Sachde Ave**

19. (a) **MAR 26 1947** (b) **H. H. H. H.**
(Date received local registrar) (Registrar's signature)

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 **0**

23. Signature **E. W. Williams** (M. D. or other) **0**
Address **2607 N. Whittier** Date signed **3/25/47**

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

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



Licensed Embalmer No. 1173

P. O. Address 3517 S. Leland av

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.