No. 2
2-45
7-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1947

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

11668

State File No.

Registrar's No. 3613

1. PLACE OF DEATH:

(a) County: None

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

(c) Name of hospital or institution: Homer G. Phillips
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: abt 22 hrs (Specify whether years, months or days)

In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: None

(c) City or town: Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 4225a Kennerly Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: WASHINGTON, Fontella Marie

3. (b) If veteran, name war: --------

3. (c) Social Security No. 495-12-7651

4. Sex: Female

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: Stacy

6. (c) Age of husband or wife if alive: abt 48 years

7. Birth date of deceased: January (Month) 30, (Day) 1904 (Year)

8. AGE: Years 43 | Months 2 | Days -0- | If less than one day ____ hr. ____ min.

9. Birthplace: Saint Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: --

MOTHER FATHER

12. Name: James Sears

13. Birthplace: Unavailable (City, town, or county) (State or foreign country)

14. Maiden name: Theo Johnson

15. Birthplace: Columbia (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs Theo Moseley

(b) Address: 4225a Kennerly Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-5-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Washington Park

18. (a) Signature of funeral director: Charles J. Gates

(b) Address: 4107 Finney Avenue

19. (a) APR 5 1947 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30th year 1947 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Subarachnoid Hemorrhage

Due to: Hypertension

Due to:

Other conditions: BD
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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) Months of injury: 3

23. Signature: Dr. Alfred J. Perry (M. D. or other)

Address: 1300 Clark Avenue Date signed: 4-3-47

(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 K. Cunningham, Registered Apprentice No. 452,

working under my personal supervision.

Signed

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.

No. 2B
1—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11668

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 3613

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: ____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME Fontella Washington

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex ____ 5. Color or race ____ 6. (a) Single, widowed, married, divorced ____

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased ____ (Month) ____ (Day) ____ (Year)

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

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

10. Usual occupation ____

11. Industry or business ____

FATHER 12. Name ____

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

MOTHER 14. Maiden name ____

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

16. (a) Informant ____

(b) Address ____

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

(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____

(b) Address ____

19. (a) 4-12-48 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1947 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h. alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Subacute Hemorrhage	
Due to nephritis Pregnacy	
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 ____

23. Signature ____ (M. D. or other) ____

Address ____ Date signed ____

SUPPLEMENTARY