

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 9 1947  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15330  
Registrar's No. 4393

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution 2707 1/2 Eugenia  
(d) Length of stay: In hospital or institution  
In this community years, months or days

3. (a) PRINT FULL NAME Queen Lathon  
3. (b) If veteran, name war 3. (c) Social Security No.  
4. Sex F 5. Color or race Negro  
6. (a) Single, widowed, married, divorced, widow  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Feb 12 1903  
(Month) (Day) (Year)

8. AGE: 44 Years 2 Months 13 Days  
If less than one day hr. min.

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

10. Usual occupation HOUSEWORK

11. Industry or business

12. Name MOSE WILLIAMS

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

14. Maiden name SARAH RAY

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

16. (a) Informant FRED BRIDGES

(b) Address 2334 SPRUCE

17. (a) (b) Date thereof May 2, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director

(b) Address 2915

19. (a) APR 30 1947 (Date received local registrar)

J. P. Medeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County  
(c) City or town St. Louis  
(d) Street No. 2707 1/2 Eugenia  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 25 year 1947 hour 4 minute 00 P.M.  
21. I hereby certify that I attended the deceased from Jan 1, 1947, to April 25, 1947  
that I last saw her alive on April 23, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Due to Cerebral apoplexy  
Hypertension  
Due to

Other conditions (Include pregnancy within 3 months of death) 830

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? (c) Means of injury

23. Signature: Willpound (M. D. or other)

Address: 2337 Market Date signed: 4/27/47

---

---

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

*G. A. Green*

Licensed Embalmer No.

*2743*

P. O. Address

*2915 Franklin*

**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.