

FILED MAY 1 1947
318

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. **4141**

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: **City Infirmary**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 yr., 9 mos., 29 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. **5800 Arsenal Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LITTLE, MARY**

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

4. Sex **Female** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **John Little** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 4th, 1885**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 1 14 hr. min.

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

10. Usual occupation **Nil**

11. Industry or business _____

MOTHER FATHER { 12. Name **Tom Carter,**

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

14. Maiden name **Babe ?**

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

16. (a) Informant **City Infirmary records,**

(b) Address **5800 Arsenal Street**

17. (a) **Burial** (b) Date thereof **4-25-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem**

18. (a) Signature of funeral director **Ellis E. F. N. HOME**

(b) Address **2820 Stoddard St.**

19. (a) **APR 22 1947** (b) **J. F. Fredrick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April 3** day **18th**,
year **1947** hour **1** minute **50** A.M.

21. I hereby certify that I attended the deceased from **July 2,**
19 **45** to **4-18-** 1947;
that I last saw h. **er** alive on **April 18th,** 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebro-Vascular Lesion April 16, 1947.**

Due to **Hemiparesis-1945 Plus.**

Due to **83**

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

Major findings: _____
Of operations: _____

Of autopsy: _____

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 **Palmer Prussus Bouchel** (M. D. or other) _____

Address **Infirmary** Date signed **4/18**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 L. Boyka
....., Registered Apprentice No. M
working under my personal supervision.

Signed Liamic Boyka
Licensed Embalmer No. 2746
P. O. Address St Louis Mo

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.