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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15702

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4574

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Barnes Hospital, O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 WKS (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS 96

(c) City or town CLAYTON, NR 3
(If outside city or town limits, write "RURAL")

(d) Street No. 110 S. CENTRAL AV
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ALLA MAE SUGG

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE O

6. (b) Name of husband or wife —

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

7. Birth date of deceased JUNE (Month) 13 (Day) 1905 (Year)

8. AGE: Years 41 Months 10 Days 17 If less than one day hr. min.

9. Birthplace HICKMAN Co (City, town, or county) Ky (State or foreign country)

10. Usual occupation NURSE

11. Industry or business NURSING

FATHER
12. Name J. C. SUGG
13. Birthplace HICKMAN Co (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name BETTY RINGO
15. Birthplace — (City, town, or county) Mo (State or foreign country) O

16. (a) Informant MRS PATTYE MAE FIELDS
(b) Address 404 4ST. FULTON, Ky

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-2-1947 (Month) (Day) (Year)
(c) Place: burial or cremation UNION Cem. FULTON, Ky

18. (a) Signature of funeral director ROWLAND MORTUARY
(b) Address 4355 WASHINGTON AV.

19. (a) MAY 5 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30 year 1947 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from Mar. 1, 1947, 19 , to 30 April, 1947; that I last saw her alive on 30 April, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal Obstruction	3 weeks
Due to Aspiration Pneumonia	2 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations Multiple intestinal obstructions.
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 O

23. Signature Russell Crider M.D. (M. Doctor)
Address Barnes Hospital Russel J Crider Date signed 30 Apr '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.....Konald Yahnke.....

Licensed Embalmer No.....3917.....

P. O. Address....4355 Washington Ave

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.