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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. **15860**
Registrar's No. **976**

FILED **MAY 8 1947**
Registration District No. **317**

Primary Registration District No. **3068**

1. PLACE OF DEATH:
(a) County **St. Louis,**
(b) City or town **Maplewood,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence; 7426 Flora Ave.,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Maplewood,**
(If outside city or town limits, write "RURAL")
(d) Street No. **7426 Flora Ave.,**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **EMMA J. LAYLAND.**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **29**
year **1947** hour **4:00** minute **A.** M.
21. I hereby certify that I attended the deceased from **Jan 22**
1944 to **Apr 29** **1947.**
that I last saw her alive on **April 29** **1947;**
and that death occurred on the date and hour stated above.

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed.**
6. (b) Name of husband or wife **Cyrus Layland,**
6. (c) Age of husband or wife if alive **Dec'd.** years
7. Birth date of deceased **August 10, 1878.**
(Month) (Day) (Year)
8. AGE: Years **68.** Months **8.** Days **19.**
If less than one day hr. _____ min. _____

Immediate cause of death **Cancer of Stomach**
Hypertension
One Paralytic Stroke, mild
Due to _____
Due to **46**

9. Birthplace: _____
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home.**
11. Industry or business _____

Other conditions **Migraine attacks**
(Include pregnancy within 3 months of death) **6 months**
Major findings:
Of operations _____
Of autopsy _____

MOTHER FATHER {
12. Name **Moses Kennedy Ross.**
13. Birthplace **Unknown.** **U. S. A.**
(City, town, or county) (State or foreign country)
14. Maiden name **Malissa Moore.**
15. Birthplace **Ohio.**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Miss Ruth Ellen Ley.**
(b) Address **7426 Flora, Maplewood, Mo.,**
17. (a) **Cremation.** (b) Date thereof **5/2/47.**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove Crematory.**
18. (a) Signature of funeral director **C.R. Lupton & Sons.,**
(b) Address **7233 Delmar Blvd.,**
19. (a) **5-2-47** (b) **Beulah Hays**
(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 **D**
Signature **Leroy E. Ellison** **MD** (M. D. or other) **MD**
Address **3610 So Broadway, St Louis** Date signed **4-30-47**

SEP 3 1947

Dr. A. O. Wilson
Off - 3610 So Broad Way 1:30 P.M. - 4:30 P.M.
PR - 4683
No. 7346 MYRTLE, Maplewood
ST - 3783

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.

Not Embalmed

Signed *Raymond L. Morris*

Licensed Embalmer No. *4330*

P. O. Address *Maplewood, N.J.*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. manRegistration District No. 317Primary Registration District No. 3068Registrar's No. 976

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Maplewood
(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 _____)

In this community _____
years, months or days3. (a) PRINT FULL NAME Emma J. Layland

3. (b) If veteran, name war _____

3. (c) Social security No. _____

4. Sex F 5. Color w 6. (a) Single, widowed, married, divorced wid
race _____6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years7. Birth date of deceased aug 10
(Month) (Day) (Year)8. AGE: Years 68 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 _____

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant _____
(b) Address _____17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 29
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

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
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tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

1 JUL 22 1969

15860