

No. 2
-5-43
-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18680**

FILED JUN 5 1947
318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **5199**

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2143a Gratiot St.
(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

3. (a) PRINT FULL NAME Ethel Cargo
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color of race Col.
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 March 19th, 1890
(Month) (Day) (Year)

8. AGE: Years 57 Months 2 Days 4
If less than one day _____ hr. _____ min.

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

10. Usual occupation Domestic

11. Industry or business _____

MOTHER FATHER
12. Name Ely Sanders 9
13. Birthplace Unknown ?
(City, town, or county) (State or foreign country)
14. Maiden name Liza
15. Birthplace Unknown ?
(City, town, or county) (State or foreign country)

16. (a) Informant Rosa Martin
(b) Address 2143a Gratiot St.

17. (a) Burial (b) Date thereof 5/27/47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St.

19. (a) MAY 26 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2143a Gratiot St. 9
22 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1947 hour _____ minute 10A M.
21. I hereby certify that I attended the deceased from March 24
1947, to May 23 1947.
that I last saw her alive on May 20 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Kidney infection and bladder infection Duration 3 months
1947
Due to _____
Due to _____

Other conditions Pelvic Infection. 3 months
(Include pregnancy within 3 months of death)

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
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 Leroy E. Ellison, MD (M. D. or other) MD
Address 3610 1/2 Broadway, St. Louis Date signed 5-24-47

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 myself

....., Registered Apprentice No.
working under my personal supervision.

Signed Lonnie Boykin

Licensed Embalmer No. 2946

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Wm 78680*

Registration District No.

Primary Registration District No.

Registrar's No. *5199*

1. PLACE OF DEATH:

(a) County *St. Louis*
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME *Ethel Cargo*

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 _____ Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *4-19-48* (b) *J. F. Bredes*
(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 *Mar* 23
year *1947* hour _____ minute _____ M.

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

*+ bladder
Kidney + pleuric infection*
Due to _____
*not due to gonorrheal disease
but due to infection of kidney.*
Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

