

FILED JUN 5 1947

318

1003

5216

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County HOMER & PHILLIP HOSPITAL
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
HOMER & PHILLIP HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY
(Specify whether
In this community 19 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. LOUIS
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2207 DEL MAR
21 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME

MARY WALKER

3. (b) If veteran, name war

5

3. (c) Social Security No. NONE

4. Sex F. MALE

5. Color or race NEBKA

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHN

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased 7 (Month) 28 (Day) 1905 (Year)

8. AGE:

Years 41 Months 9 Days 20 If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name RUBIN JAMES

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

14. Maiden name MATILDA SMITH

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

16. (a) Informant JOHN WALKER

(b) Address 2207 DEL MAR

17. (a) REMOVAL (b) Date thereof 5-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MRS M PHILIPSON

18. (a) Signature of funeral director Dennis Love

(b) Address 3113 WASHINGTON AVE
MAY 26 1947

19. (a) (Date received local registrar) (b) J. F. Bredeek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month May day 23rd
year 1947 hour 15:00 minute P. M.

21. I hereby certify that I attended the deceased from
..... 19..... to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Meningo-Encephalitis
(type undetermined)
acute

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death) 27

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?

While at work? (Specify type of place).....
(e) Means of injury 3

23. Signature Patrick E Taylor (M. D. or other)
Address Deputy Coroner Date signed 5-26-47

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

MOTHER FATHER

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.....

W. C. Laude Gordon

Licensed Embalmer No.....

3487

P. O. Address.....

457 5 Aldine

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.