

No. 2
-12-45
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 15 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25519

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7345

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 days
(Specify whether
In this community 15 yrs
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. 18 3444 Walnut
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Sam Fisher
(b) If veteran, name war NO
(c) Social Security No. unk

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 2
year 1947 hour 5 minute 20 A.M.
21. I hereby certify that I attended the deceased from
July 31, 1947, to August 2, 1947
that I last saw him alive on August 2, 1947
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased 3 10 1890
(Month) (Day) (Year)

Immediate cause of death.....
Coronary Occlusion
Duration Unk

8. AGE: Years Months Days If less than one day:
57 4 22 hr. min.

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

9. Birthplace Lexton Miss.
(City, town, or county) (State or foreign country)
10. Usual occupation Laborer

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

MOTHER FATHER
11. Industry or business.....
12. Name George Rodgers
13. Birthplace Homes County Miss.
(City, town, or county) (State or foreign country)
14. Maiden name Levenia Davis.
15. Birthplace Homes County Miss.
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Sam Fisher
(b) Address 3444 Walnut
17. (a) Removal (b) Date thereof 8/7/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East St. Louis, Ill
18. (a) Signature of funeral director P.M.C. Green
(b) Address 3517 Laclade Ave.
19. (a) AUG 6 1947 (b) J. F. Baedek
(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.....
23. Signature J.M. Whittier (M. D. or other) D.
Address 2601 N Whittier Date signed 8-2-47

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.....

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

Signed.....

Melvin E. Green

Licensed Embalmer No.....

4428

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. Aug
Registrar's No. 7345

Registration District No. 318

Primary Registration District No. 1003

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 _____ (Specify whether _____)
years, months or days

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased much (Month) 20 (Day) 1901 (Year)

8. AGE: Years 57 Months 4 Days 18 If less than one day hr. _____ min. _____

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

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) J. F. Brudeck (Date received local registrar) _____ (Date of 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 _____

20. DATE OF DEATH: Month _____ Day _____
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 _____
Due to _____
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 _____

MEDICAL CERTIFICATION

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SEP 2 1947

S-25519

0707 me