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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **25773**

FILED JUL 21 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6629**

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 **Primary ST. Marys Hospital 1536 Papin St.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **(1) Month** (Specify whether years, months or days).

8. (a) PRINT FULL NAME **Eliza Latimore**

8. (b) If veteran, name war **None** 8. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **John Latimore** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **January 1st 1893** (Month) (Day) (Year)

8. AGE: Years **54** Months **6** Days **10** If less than one day hr. min.

9. Birthplace **Gibson Georgia** (City, town, or county) (State or foreign country)

10. Usual occupation **House Wife domesticts**

MOTHER FATHER  
12. Name **Nelson Davis Virginia**  
18. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name **Betsie ?**  
15. Birthplace **Virginia** (City, town, or county) (State or foreign country)

16. (a) Informant **Sawson Latimore**  
(b) Address **1512 R. South, 3rd Street**

17. (a) **Removal** (b) Date thereof **7/14/47** (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation **Little Rock Ark**

18. (a) Signature of funeral director **Price & Walker**  
(b) Address **2829 Washington Blvd**

19. (a) **JUL 14 1947** (Date received local registrar) (b) **J.F. Buddick** (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. **1512 Rear. So. 3rd Street** **9**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? **23** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **11th**  
year **1947** hour **4** minute **15** P. M.

21. I hereby certify that I attended the deceased from **June 15, 1947** to **July 11, 1947** that I last saw her alive on **July 11, 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Supraventricular Cardiac Arrhythmia**  
**General Disease**

Due to **N**

Due to **121**

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations  
Of autopsy **70**  
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) (e) Manner of injury **3**

23. Signature **J.F. Buddick** (M. D. or other)

Address **2829 Washington Blvd** (Date signed **7/14/47**)

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

JUL 14 1955

*Emul separate cert to be filed*

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.....

*Teaffine E. Cooper*

Registered Apprentice No. *505*

working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Aug  
Registrar's No. 66209

Registration District No. 318 Primary Registration District No. 1003

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:  
(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 Elyia Latimore  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased..... (Month) (Day) (Year)  
8. AGE: Years 54 Months Days If less than one day  
hr. min.

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

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)  
(Burial, cremation, or removal) (c) Place: burial or cremation.....

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

19. (a) 7-14-1947 (b) J F Breese  
(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 CERTIFICATE FROM  
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 felt saw..... 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.....

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.....

23. Signature..... (M. D. or other)  
Address..... Date signed.....

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

SUPPLEMENTARY

AUG 14 1947

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