

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:  
**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  
**60 yrs** (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **000**  
(c) City or town **St Louis**  
(If outside city or town limits, write "RURAL") **17**  
(d) Street No. **1136 Aubert** **9**  
(If rural, give location) **12**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **19**  
year **1947** hour **6** minute **22** P.M.

21. I hereby certify that I attended the deceased from **7/17**, 19 **47** to **July 19**, 19 **47**  
that I last saw h. or alive on **July 19**, 19 **47**  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
**Degenerative Heart Disease with Au- ricular Fibrillation**

Duration

**Unk**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause of 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)  
White at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **Dr. Daniels** (M. D. **0**)  
Address **2601 N Whittier St** Date signed **7-21-47**

3. (a) PRINT FULL NAME **Mary Long**

3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 3 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **9** **15** **1845**  
(Month) (Day) (Year)

8. AGE: Years **101** Months **10** Days **4** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Frankfort KY** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **UNK** 9

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

14. Maiden name **UNK**

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

16. (a) Informant **Mrs. Carolyn Knight**

(b) Address **1136 Aubert**

17. (a) **St. Peter's** (b) Date thereof **7-23-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cem**

18. (a) Signature of funeral director **W. Harrison**

(b) Address **2906 Sawtooth Blvd**

19. (a) **JUL 23 1947** (b) **J. F. Bredeck**  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USING 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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard Ave

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.