

No. 2
1747
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25944
Registrar's No. 7089

National Office of Vital Statistics
FILED AUG 8 1947
Registration District No. 318

Primary Registration District No. 1003

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

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mos; 12 days
(Specify whether
In this community 1 yr
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2601 N Phillips 9
636 Atlanta
(Specify street name and location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Bessie Pope
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex Female 3 Color or race Negro
6. (a) Single, widowed, married, divorced... Separated
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased August 30 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 10 16hr.min.

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

10. Usual occupation Nil

11. Industry or business Nil

12. Name Benjamin Gamble
13. Birthplace Unk Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Emma Young
15. Birthplace Unk Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant S Jenkins
(b) Address Homer G Phillips Hospital

17. (a) Removal (b) Date there 7-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of medical director [Signature]
(b) Address 3500 Patton
JUL 31 1947
19. (a) J. F. Breneck (b) J. F. Breneck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 16
year 1947 hour 10 minute 20 AM.

21. I hereby certify that I attended the deceased from April 7, 1947 to July 16, 1947
that I last saw her alive on July 16, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Far-Advanced Pulmonary Tuberculosis Unk
Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 1/2

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

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

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

Reclaimed from Anatomical Board - 7-30-1947

07

CA

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.....

Tom Carter

Registered Apprentice No. *500*

working under my personal supervision.

Signed.....

Howard F. Rowland

Licensed Embalmer No. *3114*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Aug
Registrar's No. 7089Registration District No. 318Primary 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 _____
_____ years, months or days3. (a) PRINT FULL NAME Bessie Pope3. (b) If veteran, _____ name war _____
3. (c) Social Security No. _____4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced sepa

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

7. Birth date of deceased Aug 30 1900
(Month) (Day) (Year)8. AGE: Years 42 Months _____ Days _____ (If less than one day, hr. _____ min. _____)9. Birthplace Miss
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bredek
(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 Aug 16
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

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 Ben L. Daniels (M. D. certifies)Address 2601 Whittier Date signed _____

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

SUPPLEMENTARY

AUG 14 1942

S-25944/