V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25953

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6686

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:
1720 Mississippi Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 600

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1720 Mississippi Avenue 9
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MARTHA L. PRESSON

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced S 0

6. (b) Name of husband or wife

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

7. Birth date of deceased November 11, 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	8	3	hr. min.

9. Birthplace Camden, Tennessee 1
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business at home

FATHER
12. Name William Presson 9
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Chauncey D. Presson
(b) Address 1720 Mississippi Avenue

17. (a) burial (b) Date thereof 7-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East Prairie, Missouri

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue

19. (a) Nill 16 (b) J. F. Bredeck
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1947 hour 8:00 minute am M.

21. I hereby certify that I attended the deceased from 1-17- 1947, to 7-13- 1947
that I last saw her alive on 7-13- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage — Duration 24 hrs

Due to Hypertensive Heart Disease — Years

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. A. Seib (M. D. or other) MD

Address 2323 Lafayette Date signed 7-14-47

(Licensed Embalmer's Statement on Reverse Side)

98313

Dr. Geo. Seib
2323 Lafayette Av.

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 C W Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.