

**FILED AUG 8 1947**  
318

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7107**

**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 **18 days** (Specify whether

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME **Essie Merlin Vincent**

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

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

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

7. Birth date of deceased **6 17 47**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**18** hr. min.

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name **Mary Jane Vincent**

15. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ether M. Sherrard, R.N.**

(b) Address **2601 N. Whittier**

17. (a) **Anatomical Board** (b) Date thereof **7-10-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington**

18. (a) Signature of funeral director **W. R. Highton**

(b) Address **3100 Cutler St.**

19. (a) **JUL 31 1947** (Date received local registrar) **J. F. Brudick** (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **ood**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **17**  
(d) Street No. **1319 N. 11th St.** (If rural, give location) **9**  
**25** (e) Citizen of foreign country?..... (Yes or No) **0**  
If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **7** day **5**  
year **1947** hour **9:00** minute **P.M.**

21. I hereby certify that I attended the deceased from **10:52 P.M.**  
**6-17-** 19**47** to **9:00 P.M.** 19**47**  
that I last saw her alive on **7-5** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Lungs: Lobar Pneumonia**

Due to.....

Due to..... **108**

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy..... **AS Above**

**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..... **0**

23. Signature **W. R. Highton** (M. D. or other) **0**

Address **2601 N. Whittier** Date **7-9-47**

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

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**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.....

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, fact should be so stated above.**