

No. 2-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

32524

State File No.

FILED SEP 18 1947

Registration District No. 310

Primary Registration District No. 1003

Registrar's No. 8435

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: 10 days
(Specify whether in this community 3 yrs years, months or days)

3. (a) PRINT FULL NAME Lena Gardner

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Female

5. Color or race Col.

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: October 4 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>10</u>	<u>29</u> hr. min.

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

10. Usual occupation: Domestic

11. Industry or business.....

MOTHER FATHER

12. Name: Henry Stovall

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

14. Maiden name: Grace Berry

15. Birthplace: Helena Montana
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Anna Smith

(b) Address: 1527a. Carr St.

17. (a) Removal
(Burial, cremation, or removal)

(b) Date thereof: 9/6/47
(Month) (Day) (Year)

(c) Place: burial or cremation: Okalona, Miss.

18. (a) Signature of funeral director: Ellis Funeral Home

(b) Address: 2820 Stoddard St.

19. (a) SEP 5 1947
(Date received local registrar)

(b) J. A. Bredbeck
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1000

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

(d) Street No. 1527 Carr
25 (If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 3
year 1947 hour 8 minute P M.

21. I hereby certify that I attended the deceased from August 24, 1947 to September 3, 1947
that I last saw him er alive on September 3, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion

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)

While at work?..... (Specify type of place)

23. Signature: J. B. Clifton (M.D.)
Address: 2601 N. Whittier Date signed: 9-6-47

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.....

Fulton E. Culkin

Licensed Embalmer No.....

4198

P. O. Address.....

St Louis 13 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.