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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED OCT 4 1947 318

Primary Registration District No. 1003

Registrar's No. 8920

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 Phillips Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 yrs  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
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. 2224 Hickory 9  
(If rural, give location)

(e) Citizen of foreign country? (22) (Yes or No) 0

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANNIE SYLVESTER

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

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20<sup>th</sup>  
year 1947 hour 9:30 minute A. M. 10

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex FEMALE 5. Color or race col

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ days

7. Birth date of deceased Feb 15 1873  
(Month) (Day) (Year)

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>5</u>	_____ hr. _____ min.

Duration \_\_\_\_\_

Due to Chronic Myocarditis

Due to Nephritis

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

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

Major findings: \_\_\_\_\_

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

12. Name not known

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

14. Maiden name not known

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mary Johnson

(b) Address 2224 Hickory

17. (a) Burial (b) Date thereof 9-25-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Walter J. Bradeck

(b) Address 2769 Franklin

19. (a) SEP 24 1947 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

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 3

23. Signature Alfred J. Curry (M. D. or other) 3

Address Deputy Coroner Date signed 9-21-47

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

087

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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.....

*S. J. Watson*

Licensed Embalmer No.....

*2698*

P. O. Address.....

*2769 Cherokee*

**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.**