No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

33297

State File No. .....

FILED SEP 22 1947

Registration District No. 3/4

Primary Registration District No. 6076

Registrar's No. 1939

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 341 days (Specify whether
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1 000

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

(d) Street No. 2311 Cole 9
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME Aretha Henry

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

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

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced Divorced 5

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

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

7. Birth date of deceased January (Month) 27 (Day) 1915 (Year)

8. AGE:

Years	Months	Days	If less than one day
32	7	11	..... hr. ..... min.

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

10. Usual occupation Nil

11. Industry or business .....

FATHER
12. Name Ed Boyd
13. Birthplace ..... (City, town, or county) Miss. (State or foreign country) 1

MOTHER
14. Maiden name Emma Jones
15. Birthplace ..... (City, town, or county) Miss. (State or foreign country) 1

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-15-47 (Month) (Day) (Year)

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

18. (a) Signature of funeral director John T. Hinston

(b) Address 2829 Washington Blvd.

19. (a) 9-15-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7
year 1947 hour 6 minute 00 a.m.

21. I hereby certify that I attended the deceased from 10-1-46, 19..., to 9-7-47, 19...; that I last saw her alive on 9-7-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	18 mo. (?)
Due to Tuberculous meningitis	2 wks. (?)
Due to 136	
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? ..... (e) Means of injury 0

23. Signature W. C. Banton II (M. D. or other M.D.)

Address Robt. Koch Date signed 9-8-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

SEP 23 1940

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 Teofilo B. Cooper, Registered Apprentice No. 505, working under my personal supervision.

Signed James Lyall

Licensed Embalmer No. 4441

P. O. Address 2829 Washington

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.