

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

FILED OCT 24 1947 318
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution **4220 West Papin St.**
(d) Length of stay: In hospital or institution **About 40 years**
In this community **About 40 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis**
(d) Street No. **4220 West Papin St.**
(e) Citizen of foreign country? **18** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Elizabeth Sexton**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **14th.**
year **1947** hour **3:30** P.M. minute..... M.

4. Sex **Female** 5. Color **Negro** (a) Single, widowed, married **married**
6. (b) Name of husband or wife **Lshan** 6. (c) Age of husband or wife if **6 - 2 - 1818**
7. Birth date of deceased (Month) **6** (Day) **2** (Year) **1818**

21. I hereby certify that I attended the deceased from **Sep 29**, 19**47**, to **Oct 14**, 19**47**
that I last saw her **or** alive on **Oct. 14th.**, 19**47**
and that death occurred on the date and hour stated above.

8. AGE: Years **9** Months **4** Days **12** If less than one day..... min.
9. Birthplace **Chicago Ill.** (City, town, county) (State or foreign country)

Immediate cause of death **Cerebral Hemorrhage**
Due to.....
Due to **Chronic Nephritis & Valvular**
Other conditions **of Heart**
(Include pregnancy within 3 months of death)

10. Usual occupation **House wife**
11. Industry or business.....
12. Name **William Jackson**
13. Birthplace **Chicago Ill.**
14. Maiden name **Margaret Fisher**
15. Birthplace **Unknown**

Major findings: **12/1**
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause of which death should be charged statistically.

16. (a) Informant **Mr. Reynolds**
(b) Address **1220 West Papin St.**
17. (a) **Burial** (b) Place thereof **St. Peter & Paul**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial **3103 Washington Ave**
18. (a) Signature of funeral director **Bennie Lou**
(b) Address **3103 Washington Ave**
19. (a) **OCT 16 1947** (b) **J.F. Bredack**
(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? (Specify type of place)
While **work?** (Specify type of place)
23. Signature **Samuel Stetson** M. D. or other.....
Address **925 N. Jefferson Ave.** Date signed **Oct. 16th.**

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.....

W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. *Nov*

Registration District No. *3/8*

Primary Registration District No. *1003*

Registrar's No. *9613*

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: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME

Elizabeth Sexton

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

4. Sex *F* 5. Color *B* 6. (a) Single, widowed, married, divorced *m*

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

7. Birth date of deceased *June 2*
(Month) (Day) (Year)

8. AGE: *69* Years Months Days If less than one Day
 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *10-16-47* (b) *J. F. Bredack*
(Date received local registrar) (Registrar's Signature) 1947

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* Year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

S-36255

Ja 8510