

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

FILED DEC 6 1947

Registration District No. **318** Primary Registration District No. **100**

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: In hospital or institution 4 days
 (Specify whether
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1707 Biddle St
25 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Luella Willis
 3. (b) If veteran, name war.....
 3. (c) Social Security No. 488-188344

MEDICAL CERTIFICATION.

20. DATE OF DEATH: Month Nov. day 19
 year 1947 hour 3 minute 30 A. M.

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased: 2 (Month) 9 (Day) 1900 (Year)

21. I hereby certify that I attended the deceased from Nov. 15 1947 to Nov. 19 1947
 that I last saw her alive on Nov. 19 1947
 and that death occurred on the date and hour stated above.
 Immediate cause of death Hypertensive Encephalopathy; Chronic Nephritis with Uremia
 Duration UNDET

8. AGE: Years Months Days If less than one day
47 9 9 hr. min.

Due to.....
 Due to.....
 Other conditions None
 (Include pregnancy within 3 months of death)

9. Birthplace Dutton town
 (City, town, or county) (State or foreign country)
 10. Usual occupation Clerk

11. Industry or business.....
 12. Name Unknown
 13. Birthplace.....
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace.....
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations.....
 Of autopsy No

16. (a) Informant Harris Willis
 (b) Address 1707 Biddle St
 17. (a) Burial (b) Date thereof 11-24-47
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood
 18. (a) Signature of funeral director Harris A. Brown
 (b) Address 1405 Biddle St
 19. (a) NOV 21 1947 (b) J. F. Brideck
 (Date received local registrar) (Registrar's signature)

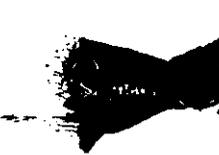
22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?..... (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?.....
 While at work?..... (Specify type of place) Means of injury.....
 Signature Escos & Daniels (M. D. or other).....
 Address 2601 N. Whittier Date signed 11/20/47

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

MOTHER, FATHER

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.

 *Frank S. Newell*
Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(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 Lulla Willis

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

4. Sex F 5. Color or race B 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 Feb. 9 (Month) (Day) (Year)

8. AGE: Years 47 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Clerk

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) J. F. Bredeek (Registrar's signature)

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 _____ day _____ year 1947 hour _____ minute _____ M.

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

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

410345

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