

S. No. 2  
-12-45  
5-17-39  
P. X47309

FILED DEC 31 1947

318

Registration District No. \_\_\_\_\_

1003

Primary Registration District No. \_\_\_\_\_

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:  
3004a Pine Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 25 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Laura Haley

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Alex Haley 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 15, 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>2</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business none

12. Name Unknown 9

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

14. Maiden name Angeline Birdstone

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

16. (a) Informant Leona Johns

(b) Address 3004a Pine St.

17. (a) Burial (b) Date thereof 12/16/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Allen Davis

(b) Address 3506 Franklin Ave.

19. (a) None (b) J. F. Brebeck  
(Date received local copy) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oaw  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 9  
(d) Street No. 3004a Pine Street  
21 (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9  
year 1947 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from Dec 1<sup>st</sup> 1947 to Dec 9<sup>th</sup> 1947  
that I last saw her alive on Dec 9<sup>th</sup> 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute CARDIAC Dilatation

Due to \_\_\_\_\_ 1 day

Due to \_\_\_\_\_

Other conditions Acute Gastro Enteritis  
(Include pregnancy within 3 months of death) 7 days

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1/20

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 A. E. Haley (M. D. or other) \_\_\_\_\_

Address 220 N. Jefferson Date signed 12/15/47

WRITE PLAINLY—USE 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.....

~~Archie Cooper~~

Registered Apprentice No. ~~505~~

working under my personal supervision.

Signed James H. Hall

Licensed Embalmer No. 1441

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.