

S. No. 2
M-1/47
7. 5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43665**
Registrar's No. **2502**

National Office of Vital Statistics
FILED DEC 17 1947

Registration District No. **377**

Primary Registration District No. **3066**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Kirkwood Clayton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis County Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Kirkwood**
(If outside city or town limits, write "RURAL")
(d) Street No. **436 Saratoga Avenue**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

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

4. Sex **Female** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Walter Ross**
6. (c) Age of husband or wife if alive years
7. Birth date of deceased **September 1st 1894**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
53	2	28	hr. min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Domestic**

11. Industry or business

12. Name **Unknown Thompson**
13. Birthplace **Alabama**
(City, town, or county) (State or foreign country)
14. Maiden name **Annie Beckwith**
15. Birthplace **Alabama**
(City, town, or county) (State or foreign country)

16. (a) Informant **Madeline Turner**
(b) Address **4447 Maffitt Avenue**

17. (a) **Burial** (b) Date thereof **12/5/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Father Dickson Cem.**

18. (a) Signature of funeral director **Chas. J. Gates**
(b) Address **4107 Finney Avenue**

19. (a) **12-9-47** (b) **Reney Shapley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **29th** h
year **1947** hour **7** minute **A.M.**

21. I hereby certify that I attended the deceased from
....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Duration
Immediate cause of death **Unknown**
Due to **Good**
Due to
Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
PHYSICIAN

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

23. Signature **Reney Shapley** (M. D. or other)
Address **Commissioner of Health** Date signed

DEC 18 1947

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.....

John K. Cunnigham

Registered Apprentice No. 452

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.