No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 9 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2387

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 830

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 12 days (Specify whether years, months or days)
In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 4244 W. Aldine St. Apt.6
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Luvenia Rivers Connors

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Col.

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

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

7. Birth date of deceased October (Month) 14 (Day) 1882 (Year)

8. AGE: Years 65 Months 3 Days 9 If less than one day hr. min.

9. Birthplace Rawliegh (City, town, or county) North Carolina (State or foreign country)

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER

12. Name George Hicks

13. Birthplace Rawliegh (City, town, or county) North Carolina (State or foreign country)

14. Maiden name SOFIE TUCKER

15. Birthplace Rawliegh (City, town, or county) North Carolina (State or foreign country)

16. (a) Informant Lovie M. Jones

(b) Address 4244 W. Aldine St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-27-48 (Month) (Day) (Year)

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

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 S Todd St.

19. (a) JAN 27 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23 year 1948 hour 9 minute 30 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 Atelectasis of lungs
Carcinoma Hypertrophy Prostate
While undergoing X Ray
Died Removed to City Hospital #2 on Jan 23rd 1948

Due to

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

23. Signature Patrick E. Langan (M. D. or other)

Address Date signed 1/23/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Fulton E Culkin

Licensed Embalmer No. 498

P. O. Address St Louis 103 Mo

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.