No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JAN 16 1948

State File No. 2967

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 255

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 7 da (Specify whether

In this community 20 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0 a d

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

-7-

(d) Street No. 5463 Gilmore Avenue (If rural, give location) 9

Memorial

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

If yes, name country

3. (a) PRINT FULL NAME EVA POTTS

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Sam

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased July 8, 1884 (Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 29 If less than one day hr. min.

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

10. Usual occupation House-wife

11. Industry or business At Home

FATHER
12. Name Samuel Crain
13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Louise Henson
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Sam Potts

(b) Address 5463 Gilmore Avenue

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1-10-48 (Month) (Day) (Year)

(c) Place: burial or cremation Duquoin, Illinois

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette

19. (a) JAN 9 1948 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7th year 1948 hour 5 minute 00 A M.

21. I hereby certify that I attended the deceased from 11/30/47, 19, to Jan. 7th, 1948 that I last saw her alive on Jan. 7th, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Rt. Breast with met. to lungs, Brain

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Recurrent Ca. of Right Breast with met. to lungs and Sternum

Duration

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 0

23. Signature Louis G. Wombre MD (M. D. or other)

Address 1515 Lafayette 1/8/48

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 C W Cooper

Licensed Embalmer No. 3890

P. O. Address 2301 Lafayette Ave

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.