. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 3 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3498

Registration District No. 377 Primary Registration District No. 6076 Registrar's No. 187

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 202 days (Specify whether
In this community 18 yrs 5 mos. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1533 Bacon (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hall, Eva Mae
3. (b) If veteran, name war
3. (c) Social Security No. 498-20-4848
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 2-3-26 (Month) (Day) (Year)

8. AGE: Years 21 Months 11 Days 16 If less than one day hr. min.
9. Birthplace Walnut Ridge, Ark (City, town, or county) (State or foreign country)
10. Usual occupation bookkeeper
11. Industry or business
FATHER
12. Name Erwin William Hall
13. Birthplace Ill. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Anna Emily Smith
15. Birthplace Ark. (City, town, or county) (State or foreign country)
16. (a) Informant hospital record
(b) Address Robert Koch Hospital
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1-22-48 (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hills Cemetery
18. (a) Signature of funeral director A. Kron L & U. Co
(b) Address 2707 N. Grand Blvd
19. (a) 1-20-48 (Date received local registrar) (b) Carl A. Shaw MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 19 day
year 1948 hour 2 minute 00 A.M.
21. I hereby certify that I attended the deceased from 7-1-47, 19, to 1-19-, 1948;
that I last saw her alive on 1-19-48, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	15 mos?
Due to	
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 Bernard Friedman (M. D. or other) MD
Address Robert Koch Hospital Date signed 1-19-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

FEB 3 1948

OCT 26 1949

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.....

Licensed Embalmer No. 3881

P. O. Address.....

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.