

S. No. 300
OM-10-47
ev. 5-17-39
I 3908

FEDERAL BUREAU OF VITAL STATISTICS
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH
100's

6552

State File No. _____

FILED MAR 11 1948 318

Registrar's No. 2048

Registration District No. _____

Primary Registration District No. _____

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 hrs. 5 mins
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 021

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

(d) Street No. 3058 Thomas
21 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edga Jones Twin # 1

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 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 8 48
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 13 hr. 5 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name Lena Jones

15. Birthplace Osceola Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Rhodes

(b) Address 2601 N. Whittier

17. (a) _____ (b) Date thereof FEB 20 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Dward

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) FEB 20 1948 (b) J. F. Brebeck
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 9
- year 1948 hour 9 minute 50 A.M.

21. I hereby certify that I attended the deceased from 8:45 P.M.
2-8- 19 48, to 9:50 A.M., 19 48

that I last saw him alive on 2-9- 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 W. J. Ancker (M. D. or other) _____
Address 2601 N. Whittier Date signed 2-11-48

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.

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.