No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 4 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7171

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1762

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

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: 3403 LaSalle
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 800

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

(d) Street No. 3403 LaSalle 9
(If rural, give location)

(e) Citizen of foreign country? 18 (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Hannah Warren

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female 3

5. Color or race Colored

6. (a) Single, widowed, married, divorced W 21

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 19, (Day) 1880 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	9	0	hr. min.

9. Birthplace Kosicusko, Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Ned Nash
13. Birthplace Miss.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nash
15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Abraham Warren
(b) Address 3403 LaSalle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-48 (Month) (Day) (Year)
(c) Place: burial or cremation Wynne, Arkansas

18. (a) Signature of funeral director E. B. Koonce
(b) Address 1221 N. Grand Blvd.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19, year 48 hour 6:15 minute 00 A. M.

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

Immediate cause of death

Duration

Arterial Cyanosis

Due to

Due to 83

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 3

23. Signature Alfred J. Perry (M. D. or other)

Address Deputy Coroner Date signed 2-20-48

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 Theodore T. Yandell

Licensed Embalmer No. 4243

P. O. Address 14 Wayne St. Peaster Groves

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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1762

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:

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

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Hannah Walker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 19 (Day) 88 (Year)

8. AGE: Years 67 Months 9 Days 0 If less than one day hr. min.

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

10. Usual occupation Unemployed

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)
MAR 6 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19 year 1948 hour minute 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	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

7171