

No. 300  
10-47  
5-17-39  
I 3906

FILED MAR 23 1948 318  
Registration District No.

Primary Registration District No. 1003

WRITE PLAINLY—USE 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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community 4 Mo  
years, months or days)

3. (a) PRINT FULL NAME George Livingston  
(b) If veteran, name war No  
3. (c) Social Security No. No

4. Sex Male 5. Color of race Col  
6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife None  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased November 10 1947  
(Month) (Day) (Year)

8. AGE: Years 4 Months 0 Days 0  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Mill

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name Abelse Livingston

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

16. (a) Informant S. T. Dogan

(b) Address 2107 Cole St.

17. (a) Burial (b) Date thereof 3/11/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters

18. (a) Signature of funeral director Herman J Smith

(b) Address 4247 W Labadie Ave

19. (a) MAR 11 1948 (b) J. F. Braddock  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 17  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1504 Blair  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar. day 10  
year 1948 hour 6 minute 20 a.m.  
21. I hereby certify that I attended the deceased from Mar. 7, 1948, to Mar. 10, 1948  
that I last saw him alive on Mar. 10, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Diarrhea; Dehydration  
Duration Undet.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
119

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy No  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Barbara Barover (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed 3/11/48

**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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

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.**