

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

No. 300
-1043
-1243
1908

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 10474
2895
Registrar's No. _____

FILED APR 7 1948
Registration District No. 318

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 Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 hours
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3524 Laclede 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hattie Mays
3. (b) If veteran, name war No
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 23
year 1948 hour 9 minute 57 a. M.
21. I hereby certify that I attended the deceased from 3-22 to 3-23, 1948
that I last saw her alive on March 23, 1948
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Colored
6. (a) Single, widowed, married, divorced M!
6. (b) Name of husband or wife Esau Mays
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Nov 18 1894
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
Duration Undet.
Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

8. AGE: Years 58 Months 4 Days 5
If less than one day _____ hr. _____ min.

Major findings:
Of operations _____
Of autopsy No
PHYSICIAN
Underline the cause to which death should be charged statistically.

9. Birthplace Miss. (City, town, or county) (State or foreign country)
10. Usual occupation House Wife

11. Industry or business _____
12. Name Jim Brooks
13. Birthplace Miss (City, town, or county) (State or foreign country)
14. Maiden name Martha Allen
15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant Esau Mays
(b) Address 3524 Laclede Ave
17. (a) Burial (b) Date thereon 3-29-48
(Month) (Day) (Year)
(c) Place of burial or cremation Brooklawn Washington

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? _____

18. (a) Signature of funeral director [Signature]
(b) Address 3517 Laclede Ave
19. (a) APR 24 1948 (b) J. F. [Signature]
(Date received for recording) (Registrar's signature)

While at work? _____ (Specify type of place)
Means of injury 0
23. Signature Esau L Daniels (M. D. or other)
Address 2601 N Whittier Date signed 3/24/48

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

James E. Howard, Registered Apprentice No. 514
working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 1175

P. O. Address 3517 Saeledear

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 28917

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)

3. (a) PRINT FULL NAME..... Hattie May

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

4. Sex..... ♀ 5. Color or race..... B
6. (a) Single, widowed, married, divorced..... Married

6. (b) Name of husband or wife..... Esau 6. (c) Age of husband or wife if alive..... 38

7. Birth date of deceased..... Nov. 18 1881
(Month) (Day) (Year)

8. AGE: Years..... 53 Months..... Days..... If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... April 23
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19.....
that I had seen..... above on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

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) (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

APR 27 1948

S-10471