

13-3906
17-39
10-47

FILED APR 30 1948

318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

138830
State File No. 3764
Registrar's No.

Registration District No. _____ Primary Registration District No. 1003

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 2 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Emma Austin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored

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 4 1862
(Month) (Day) (Year)

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

85 11 14 hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Clark

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

14. Maiden name Unk.

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

16. (a) Informant Julia Craig

(b) Address 2223 Randolph

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

(c) Place: burial or cremation Oakdale Cemetery

18. (a) Signature of funeral director E. B. Koonce

(b) Address 1221 N. Grand

19. (a) APR 21 1948 (b) J. F. Bredeck
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 2223 Randolph
22 (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1948 hour 9 p m minute P M.

21. I hereby certify that I attended the deceased from April 16, 1948, to April 18, 1948
that I last saw her alive on April 18, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Carcinoma
Site not known

Duration UNDET

Due to _____

Due to _____

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)

(a) Means of injury _____

23. Signature Oscar J Daniels (M. D. or other) _____
Address 2601 N Whittier Date signed 4/19/48

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

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.....

Frederic J. Yardell

Licensed Embalmer No.

4243

P. O. Address.....

*14 Myrmia St
Detroit, Mich*

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.

Registration District No. *318*

Primary Registration District No. *1803*

Registrar's No. *3764*

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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME *Emma Austin*

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 *wid*

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

7. Birth date of deceased..... (Month) *May* (Day) *4* (Year) *1948*

8. AGE: Years *85* Months *5* Days *1* If less than one day hr. min.

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

10. Usual occupation *SUPPLIER*

11. Industry or business

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

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) *J. F. Bredeek* (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 *May* year *1948* hour *11* minute *18* M.

21. I hereby certify that I attended the deceased from *1948* to *1948*; that I last saw him/her alive on *May 4*, 19*48*; 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)

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?

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

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

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

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

MOTHER FATHER

MAY 13 1948

5-13830

82-5234