S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 30 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14973

Registration District No. 297 Primary Registration District No. 6076 Registrar's No. 948

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 184 days (Specify whether
In this community 19 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3936 Page Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FORREST, LILLIE MAE
3. (b) If veteran, name war
3. (c) Social Security No. 490-22-9006
4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Joe Willie Forrest
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 16 (Day) 1925 (Year)

8. AGE: Years 22 Months 9 Days 22 If less than one day hr. min.

9. Birthplace Hayti (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Perle Leslie
13. Birthplace (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Willie Mae Dinwiddie King
15. Birthplace (City, town, or county) Arkansas (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-48 (Month) (Day) (Year)
(c) Place: burial or cremation Green Wood Cem.
18. (a) Signature of funeral director C.B. Jordan
(b) Address 3955 Page
19. (a) 4-14-48 (Date received local registrar) (b) Celia J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8 year 1948 hour 9 minute 55 P. M.

21. I hereby certify that I attended the deceased from 10-7-47, 19, to 4-8-48, 19; that I last saw her alive on 4-8-48, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1 yr. (???)
Due to	
Due to	
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

23. Signature Bernard Friedman (M. D. or other) MD
Address Robt. Koch Hospital Date signed 4-9-48

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

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 Saffine E. Cooper, Registered Apprentice No. 505, working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 4841

P. O. Address 2829 Washington

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.