

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

FILED JUL 15 1948
Registration District No. **318**

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 **1 mo; 3 weeks**
19 yrs (Specify whether years, months or days)

3: (a) PRINT FULL NAME **Mary Boyd**

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

4. Sex **Female** 5. Color or race **Negro** 6: (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased **May 11 1893**
(Month) (Day) (Year)

8. AGE: Years **55** Months **0** Days **14** If less than one day hr. -- min.

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

10. Usual occupation **Laundress**

11. Industry or business **--**

MOTHER FATHER { 12. Name **N Avery**

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

14. Maiden name **P Butler**

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

16: (a) Informant **S Jenkins**

(b) Address **Homer G Phillips Hospital**

17: (a) **Burial** (b) Date thereof **June 29 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem**

18: (a) Signature of funeral director: **Boyd Paro Funeral Home**

(b) Address **3704 Finney Ave**

19: (a) **JUN 30 1948** (b) **J. T. Bredeau**
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **0-0-6**
(c) City or town **St Louis** (If outside city or town limits, write "RURAL") **179**
(d) Street No. **209 So 16th St** (If rural, give location)
(e) **22** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **25**
year **1948** hour **2** minute **20** AM.

21. I hereby certify that I attended the deceased from **May 3,** 19 **48** to **June 25,** 19 **48**;
that I last saw h. **ex** alive on **June 25,** 19 **48**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Prob Spinal Cord Tumor** Duration **Unk**
Unqualified

Due to.....
Due to..... **57**

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 **0**

23. Signature **J. M. Whittier** (M. D. optional)
Address **2601 N Whittier** Date signed **6-25-48**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 45-48² Page Blvd

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.

Lee 7664