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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

21123

FILED JUL 15 1948

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5454**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital-Max O. Starkloff Memorial**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 mos-12 days**
In this community **4 years**
(Specify whether years, months or days)

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. **1311 N. Market St.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **RUBY MCQUEEN**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Robert** 6. (c) Age of husband or wife if alive **22** years

7. Birth date of deceased **April 19th ?**
(Month) (Day) (Year)

8. AGE: Years **22?** Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **unemployed**

11. Industry or business _____

12. Name **Arvel Arbuckle**

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

14. Maiden name **Sarah Eberhardt**

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

16. (a) Informant **M. Renard**

(b) Address **St. Louis City Hospital.**

17. (a) **Anatomical Board** (b) Date thereof **JUL 16 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial **Anatomical Board**

18. (a) Signature of funeral director **Rowland Mortuary Service**

(b) Address **4104 Manchester Ave.**

19. (a) **JUN 16 1948** **J. J. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31st**
year **1948** hour **12** minute **45** A.M.

21. I hereby certify that I attended the deceased from **2/19/48**, 19____, to **May 31st**, 19____
that I last saw her alive on **May 31st**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Aspiral along spine
congenital cystic disease
LT. lung
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **with lung abscess**

Major findings: **Multiple left lung**
Of operations _____
Of autopsy _____

Duration

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? **no** (Specify type of place) (e) Means of injury **fall**

23. Signature **1515 Lafayette** (M, D, or other) **6/1/48**
Address Date signed

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

5454

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.....

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.