

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

21441

FILED JUN 28 1948 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

5460

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2623<sup>rd</sup> SPRUCE ST.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community About 30 years years, months or days)

3. (a) PRINT FULL NAME ELMARA WARREN

3. (b) If veteran,

name war No

3. (c) Social Security No.

None4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife JILLINS 6. (c) Age of husband or wife if7. Birth date of deceased 2 - 19 - 1909  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
39 3 24 hr. min.9. Birthplace ARTESIA, MISS.  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name MORRIS AMOS13. Birthplace West Point, Miss.  
(City, town, or county) (State or foreign country)14. Maiden name ANNIE PHILLIPS15. Birthplace West Point, Miss.  
(City, town, or county) (State or foreign country)16. (a) Informant Julius Warner(b) Address 2623<sup>rd</sup> Spruce St.17. (a) Burial (b) Date thereof: 6-19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Father Dixon's Deacons Cen(a) Signature of funeral director Bessie Loue(b) Address 3103 WASHINGTON AVE.19. (a) JUN 16 1948 (Date received local registrar)  
J. J. Bradech (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. 2623<sup>rd</sup> SPRUCE ST  
22 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 13  
year 1948 hour 10 minute 30 P. M.21. I hereby certify that I attended the deceased from  
4/21 1948 to 6/13 1948  
that I last saw her alive on 6/13 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of uterus 3yr

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations No-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? Cen

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature J. J. Bradech (M. D. or other)  
 Address 2136 Chestnut Date signed \_\_\_\_\_

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**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 W. Claude Jordan

Licensed Embalmer No. 23489

P. O. Address 457 Albin

**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.**