

FILED SEP 13 1948

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1429 Cass Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)

In this community years, months or days

3. (a) PRINT FULL NAME Eddie Abram

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, Married
6. (b) Name of husband or wife Emanuel Abram 6. (c) Age of husband or wife if alive, years 20
7. Birth date of deceased March 20 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 5 6 hr. min.

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

10. Usual occupation House Wife

MOTHER FATHER

11. Industry or business.....
12. Name Rob Collins
13. Birthplace Tenn
(City, town, or county) (State or foreign country)
14. Maiden name UNK
15. Birthplace Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Emanuel Abram
(b) Address 1429 Cass Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/48
(Month) (Day) (Year)
(c) Place: burial or cremation E. Higgins Hill

18. (a) Signature of funeral director E. Higgins Hill
(b) Address 357 S. Laclede Ave

19. (a) AUG 31 1948 registrar (b) J. F. Bredeck Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1429 Cass Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
year 1948 hour 2 minute 2 M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....,
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Unresolved Pneumonia
Empyema Right Side
Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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 W. A. G. King M. D. or other) Address 1000 3 Date signed 8/30/48

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.....

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.