

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 27495
7723
Registrar's No.

Registration District No. 318

Primary Registration District No. 1003

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 15 days
48 yrs (Specify whether
In this community
years, months or days)

3: (a) PRINT
FULL NAME Mamie Bates3. (b) If veteran,
name war.

3. (c) Social Security No.

4. Sex F 3 5. Color or race Col
6. (a) Single, widowed, married,
divorced Widow
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife
alive..... years
7. Birth date of deceased MAY 6 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 3 25 hr. min.

9. Birthplace (City, town, or county) Ky (State or foreign country)10. Usual occupation HOUSE WORK

11. Industry or business

12. Name ROBERT CABELL13. Birthplace Ky (State or foreign country)14. Maiden name MARY Washington15. Birthplace Ky (State or foreign country)16. (a) Informant CHRISTINE BALDWIN(b) Address 2620 E COLE17. (a) BURIAL (b) Date thereof SEPT 4/48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place of burial or cremation GREENWOOD CEM18. (a) Signature of funeral director J. J. Moresch(b) Address 418 Monroe Bldg, 424 Belmont19. (a) SEP 2 1948 (b) J. J. Moresch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County 600
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2620 Cole
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31
year 1948 hour 5 minute A M.21. I hereby certify that I attended the deceased from
August 16, 48 to August 31, 48
that I last saw h er alive on August 31, 1948
and that death occurred on the date and hour stated above.Immediate cause of death
Cerebral HemorrhageDuration
Unk

Due to.....

Due to.....

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.....23. Signature Ed Daniels (M. D. or other)
Address 2601 N Whittier St Date signed 8-31-48

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

F. G. Shear

Licensed Embalmer No

2963

P. O. Address

4314 Delmar 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.