

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED AUG 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27855
7425
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town
(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 3 days
In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mae Belle James
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE 5. Color or race Col
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE Years Months Days If less than one day
abt 60 Unknown hr. min.

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

10. Usual occupation N/L

11. Industry or business

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant City

(b) Address 2601 N Whittier

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug 28/48 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director F. G. Green

(b) Address 4214 DELMAR BLVD

19. (a) AUG 25 1948 (Date received local registrar) J. F. Bradack (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 513 So Garrison
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
23
20. DATE OF DEATH: Month August day 23
year 1948 hour 5 minute 30 A.M.
21. I hereby certify that I attended the deceased from August 20, 1948 to August 23, 1948
that I last saw her alive on August 23, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
Arteriosclerotic Heart Disease
Duration 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?

While at work? (Specify type of place) (e) Means of injury

23. Signature O. L. Daniels (M. D. or other)

Address 2601 N Whittier Date signed 8-24-48

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

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.