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

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30850
Registrar's No. 8534

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 3 days (Specify whether)
In this community Unk
years, months or days

3. (a) PRINT FULL NAME Mary Bland

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 Unk
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unk
(Month) (Day) (Year)

8. AGE - Years alt - 52 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Nil

11. Industry or business Nil

12. Name Unk

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

14. Maiden name Unk

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

16. (a) Informant S Jenkins

(b) Address Med Dir Office-Homer G Phillips

17. (c) Anatomical Board (b) Date thereof SEP 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

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

(b) Address 4104 Manchester Ave.

19. (a) SEP 30 1948 (b) J. F. Bruckner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County ooo
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2608 Pine
(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 26
year 1948 hour 5 minute 45 AM.

21. I hereby certify that I attended the deceased from August 23, 1948 to August 26, 1948; that I last saw her alive on August 26, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Prob Cerebral Hemorrhage Duration Unk

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 O. L. Daniel (M. D. or other) _____

Address 2601 N Whittier Date signed 9-1-48

(Licensed Embalmer's Statement on Reverse Side)

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.