

FILED SEP 24 1948 318

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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 Phillips Hosp. 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution D60.A--H.G.P  
(Specify whether \_\_\_\_\_)  
In this community Since 1919  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 17  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. 1404 Blair  
(If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Roberta McCoy  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 11th  
year 1948 hour 7:30 minute A.M. 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.

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Separ.  
6. (b) Name of husband or wife Wm. McCoy 6. (c) Age of husband or wife if 64 years  
7. Birth date of deceased May - 16 - 1884  
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis, decomposed;  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 54 Months 3 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Meridian Mississippi  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Harvey Henderson  
13. Birthplace Ashville, N. Carolina  
(City, town, or county) (State or foreign country)  
14. Maiden name Liza Williams  
15. Birthplace Scuba, Mississippi  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Edsel McCoy  
(b) Address 1404 Blair Ave.  
17. (a) Burial (b) Date thereof 9/17/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Father Dickson Cemetery  
18. (a) Signature of funeral director Charles J. Gates  
(b) Address 4107 Finney Ave.  
19. (a) SEP 16 1948 (b) J. F. Bredeau  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(b) Means of injury 6  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 9/14/48

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

MOTHER FATHER

**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.....

John K. Cunningham....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. 4476.....

P. O. Address 4107 Finney Ave......

**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.**