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

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

U.S. DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38260  
State File No. 10241  
Registrar's No.

FILED DEC 8 1948 318

Registration District No. 100's

1. PLACE OF DEATH:

(a) County St. Louis

(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 9 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: Lillie Hurd

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 Charlie Hurd

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Aug 18 1879  
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 4  
If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business

12. Name James Ferris

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

14. Maiden name Annie Cushingberry

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

16. (a) Informant Jessett Crutchfield  
(b) Address 4222 B Fairfax

17. (a) Burial (b) Date thereof 11/29/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Green  
(b) Address 4214 Delmar Blvd

19. (a) NOV 26 1948 (b) J. B. Lester  
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 4222 B Fairfax (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22  
year 1948 hour 12 minute 40 p. m.

21. I hereby certify that I attended the deceased from Nov. 13 1948 to Nov. 22 1948  
that I last saw him alive on Nov. 22 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Degenerative Heart Disease;  
Generalized Arteriosclerosis

Duration Undet.

Due to 1/21/48

Other conditions Chronic Glomerular Nephritis  
(Include pregnancy within 3 months of death)  
and Uremia

PHYSICIAN

Major findings:  
Of operations

Of autopsy None

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 Doctor Daniel (M. D. or other)  
Address 2601 N Whittier Date signed 11/23/48

**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 *Raymond H. Swen*

Licensed Embalmer No. *4583*

P. O. Address *4214 Delmar*

**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.**