

FILED DEC 2 1948 318

Primary Registration District No. 1003

Registrar's No. 9999

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:
1421 Sarsfield Place
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community..... 1 month
 years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis,
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1421 Sarsfield Place
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME CORA LEE KIRKSEY

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..... June 2, 1924
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>24</u>	<u>5</u>	<u>12</u> hr. min.

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

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Claude McCain

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

14. Maiden name..... Carrie O'Neal

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

16. (a) Informant..... Dorothea Glasgard

(b) Address..... 925 N. Compton Avenue

17. (a) Burial (b) Date thereof..... 11-21-48
 (Burial, cremation, or reburial) (Month) (Day) (Year)

(c) Place: burial or cremation..... Leland, Miss.

18. (a) Signature of funeral director..... E. B. Roonee

(b) Address..... 1221 N. Grand Blvd.

19. (a) NOV 18 1948 (b) J. B. Foster
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14,
 year 1948 hour 3 minute 45 A. 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.

Immediate cause of death.....
Increased intra
cranial pressure
cause unknown

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..... 3

23. Signature..... Patrick E. Taylor, M.D. (M.D. or father)
1900 Clark Date signed..... 11-18-48

MOTHER FATHER

PHYSICIAN

Underline the cause of which death should be charged statistically.

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.....

Theodore J. Yandee

Licensed Embalmer No.

4243

P. O. Address.....

*14 Weymouth
Fifth Street*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 314

Primary Registration District No. 1003

Registrar's No. 9999

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Cora L. Kirksey

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 24 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation St Louis

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-6-48 (b) J.B. Lacater (Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 4 Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-38329