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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

41430

State File No. _____

FILED JAN 11 1949

Registrar's No. 11067

Registration District No. 318

Primary Registration District No. 1005

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 10 days
(Specify whether
In this community 30 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County gov
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2917 Laclede
(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 18
year 1948 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from
Dec. 8 1948 to Dec. 18 1948

that I last saw her alive on Dec. 18 1948
and that death occurred on the date and hour stated above.
Immediate cause of death Arteriosclerotic
Heart Disease with Decompensation. Duration
Hypertension. Undet.

3. (a) PRINT FULL NAME Mariah Feaster
3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Female 5. Color or race negre 6. (a) Single, widowed, married, divorced widow

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 abt. 73 Months _____ Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation Domestic

11. Industry or business _____

12. Name unknown

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

14. Maiden name Mary Williams

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

16. (a) Informant Clinton Wavers

(b) Address 2917 Laclede Ave

17. (a) Burial (b) Date thereof 12. 23. 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Alvin Jones

(b) Address 3644 Finney Ave

19. (a) DEC 22 1948 (b) J. B. Sasser
(Date received local registrar) (Registrar's signature)

Other conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy none
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) (Specify means of injury)
23. Signature Oscar J. Daniels (M. D. or other) _____
Address 2601 N. Whittier Date signed 12/21/48

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Louis V. Atkins
Licensed Embalmer No. 2842
P. O. Address 3644 Finney A

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 91067

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
 (b) City or town.....
(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 Mariah Feaster

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

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

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: at 73 Years Months Days If less than one day
hr. * min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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)..... (b) J. B. [Signature]
(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..... Year 1948 Number..... Minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

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

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

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

JAN 17 1949

S-41430

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