

FILED FEB 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2321
State File No. 810

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital		d. STREET ADDRESS (If rural, give location) 1101a O'Fallon Street	
3. NAME OF DECEASED (Type or Print) a. (First) Mable b. (Middle) T. c. (Last) Bronaugh		4. DATE OF DEATH (Month) (Day) (Year) 1/23/50	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 12, 1910
9. AGE (In years last birthday) 39		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pecan Picker	11. BIRTHPLACE (State or foreign country) Kosciusko, Mississippi
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clayborne Mitchell	
13b. MOTHER'S MAIDEN NAME Fannie Burks		14. NAME OF HUSBAND OR WIFE William Bronaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME William Bronaugh, 1101a O'Fallon St		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio Vasculer Hypertension nephritis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 293 X	
22. I hereby certify that I attended the deceased from 10/25, 1944 , to 1/23, 1950 , that I last saw the deceased alive on 1/23, 1950 , and that death occurred at 11 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Dr. W.C. Bridges		23b. ADDRESS 941a N. Sarah Street	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 30, 1950	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. JAN 25 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates		ADDRESS 4107 Finney Avenue	

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address. 4107 Finney Avenue

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.