

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. **791** Primary Registration District No. \_\_\_\_\_ State File No. \_\_\_\_\_ Registrar's No. **7672**

1. PLACE OF DEATH: **1008**  
 (a) County \_\_\_\_\_  
 (b) City or town **St. Louis, Mo.**  
 (c) Name of hospital or institution: \_\_\_\_\_  
**1017 N. Compton Ave.**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED: **1**  
 (a) State **Missouri** (b) County \_\_\_\_\_  
 (c) City or town **St. Louis** [21]  
 (d) Street No. **1017 N. Compton**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

3. (a) PRINT FULL NAME **Kate Godare**  
 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 **Widow**  
 6. (b) Name of husband or wife **Ferd Godare** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **January 8, 1862**  
 (Month) (Day) (Year)

8. AGE: Years **77** Months **7** Days **25** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **New Orleans Louisiana**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_  
 12. Name **William Henry Harris**  
 13. Birthplace **?**  
 14. Maiden name **MARTHA Moore**  
 15. Birthplace **?**

16. (a) Informant's own signature **M. S. Williams**  
 (b) Address **1017 North Compton**

17. (a) Burial **Greenwood Cemetery** (b) Date thereof **9/7/39**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **Pinkie L. Toney**  
 (b) Address **3129 Lucas**

19. (a) **SEP 5 1939** (b) **J. P. Brudick**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **9** day **2**  
 year **1939** hour **3** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **8/15, 1939** to **9/2, 1939**  
 that I last saw her alive on **9/2, 1939**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplectic thrombosis**  
 unprovoked  
 Due to **Apoplexia (left)**  
 caused by cerebral hemorrhage  
 Due to **Hypertension**  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: **82a**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration **15 days**  
 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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature **Vaughan Payne** (M. D. or other) \_\_\_\_\_  
 Address **3144 a haledale** Date signed **9/16/39**

**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.

*Embalmed & certified*  
*signed*

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**