

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33877
Registrar's No. 8415

NOV 13 1939 701
Registration District No. 701

Primary Registration District No. _____

1. PLACE OF DEATH 1003
(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Peoples Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Alice Washington 2593
3. (b) If veteran, name war Nil
3. (c) Social Security No. Nil
5. Color or race Col.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife A. H. Washington
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased April 12, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>5</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name R. Pasmore

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

14. Maiden name (Unk) Fry

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

16. (a) Informant's own signature A. H. Washington

(b) Address Lovejoy, Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/39
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director R. M. C. Green

(b) Address 3517 Laclède Ave.

19. (a) OCT 2 1939 (Date received local registrar) (b) _____

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED: 2
(a) State Illinois (b) County St. Clair
(c) City or town Lovejoy NR
(If outside city or town limits, write "RURAL")
(d) Street No. 4th & Totten Sts.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1939 hour 4:05 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 12, 1939, to Sept 29, 1939;
that I last saw her alive on Sept 29, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary + Myocarditis
Nephritis chronic

Due to _____

Due to _____

Other conditions 131
(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)

(a) Means of injury _____

23. Signature D. W. Thomas (M. D. or other)

Address 1730 Bond Ave Date signed 10/1/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

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

W. W. Green

Licensed Embalmer No.

1173

P. O. Address

3517 Soledad

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.