

DEC 13 1939 791
Registration District No.

Primary Registration District No.

Registrar's No. 10110

1. PLACE OF DEATH: 1003
(a) County _____
(b) City or town St Louis
(c) Name of hospital or institution: St Marys Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community _____ years, months or days) 1 day

3. (a) PRINT FULL NAME ELLA SAMPLE KILL
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 6 1898
(Month) (Day) (Year)

8. AGE: Years 41 Months 4 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife at home

11. Industry or business _____
12. Name Ben. Givens
13. Birthplace Merant. Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Corde Marshall
15. Birthplace Shelbyville Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Suey Washington
(b) Address Kenise Ill

17. (a) Removal (b) Date thereof Nov 27-30
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East St Louis Ill

18. (a) Signature of funeral director J. J. ...
(b) Address 2205 ... East St Louis Ill

19. (a) NOV 27 1939 (b) J. D. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 2-
(a) State Ill. (b) County Madison
(c) City or town Venice NR
(If outside city or town limits, write "RURAL")
(d) Street No. 1002 Calhoun St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24
year 1939 hour 10 minute 45 M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 Chronic Myocarditis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
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) _____ (Means of injury)
23. Signature Alfred Perry (M. D. or other)
Address W. ... Date signed 11-27-39

63
MARGIN RESERVED FOR BINDING
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.....

Robert A. Powell

Licensed Embalmer No. *3402*

P. O. Address. *3100 Franklin*

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.