

13515

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

3717

MAY 15 1940
Registration District No.

709

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2623 THOMAS ST.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NONE
(Specify whether years, months or days) 17 YEARS

3. (a) PRINT FULL NAME MARY BROADNAX 635

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

4. Sex FEMALE 5. Color or race COL 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JAKE BROADNAX 6. (c) Age of husband or wife if alive DEAD years

7. Birth date of deceased 4 15 1870
(Month) APRIL (Day) 15 (Year) 1870

8. AGE: Years 70 Months XX Days 7 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business DOMESTIC

12. Name ANDERSON HARRIS

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

14. Maiden name EVVA GATEWOOD

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

16. (a) Informant's own signature X. J. Cornett, Cook

(b) Address 2810 DICKSON ST.

17. (a) BURIAL (b) Date thereof 4/27/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK

18. (a) Signature of funeral director Chas. A. Kelly

(b) Address 3030 Bell Ave

19. (a) APR 24 1940 (b) J. J. [Signature]
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS
(c) City or town ST. LOUIS 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2623 THOMAS ST.
(If rural, give location)
(e) If foreign born, how long in U. S. A. U.S.A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 22
year 1940 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Apr 4
1940, to Apr 22, 1940
that I last saw her alive on Apr 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus

Due to _____

Due to _____

Other conditions (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) (e) Means of injury _____

23. Signature M. A. [Signature] (M. D. or other) us D
Address 2335 [Signature] Date signed 4-25-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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 H. 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.