V. S. No. 2
M—11-10-39
Rev. 5-17-39.
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30495

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 7772

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

1. PLACE OF DEATH:

(a) County
(b) City or town ST Louis, Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST Mary's Infirmary (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 ½ Months (Specify whether years, months or days)
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST Louis
(c) City or town ~~St. Louis~~, Mo NR (If outside city or town limits write "RURAL")
(d) Street No. 1714 Lincoln, Richmond Heights (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME Willie Grant (Darkins)
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 William H. Darkins
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 4 1890 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
50	5	11	hr. min.

9. Birthplace Cotton Plant (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Dan Wilson
13. Birthplace Unavailable (City, town, or county) Mississippi (State or foreign country)
MOTHER 14. Maiden name Minerva Griffins
15. Birthplace Unavailable (City, town, or county) Mississippi (State or foreign country)
16. (a) Informant Marsaline Smith
(b) Address 1714 Lincoln Ave. Richmond H
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.
18. (a) Signature of funeral director Chas. Gates
(b) Address 4107 Finney Ave.
19. (a) SEP 17 1940 (Date received by local registrar) (b) J. P. Wiedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15th year 1940 hour 9:00 minute P. M.
21. I hereby certify that I attended the deceased from July 1st, 1940, to September 15, 1940 that I last saw him alive on September 15th, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of cervix	
Due to: Metastases	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: Ca. of cervix & metastasis to uterus, bladder & ureters	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. L. Davis (M. D. or other)
Address Dr. Earl Williams, St. Mary's Infirmary Date signed 9/16/40

(Licensed Embalmer's Statement on Reverse Side)

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 James A. Johnson, Registered Apprentice No. ____, working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

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, above space should be left blank.