

0. 2
4-41
7-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. **30125**
Registrar's No. **2464**

FILED OCT 18 1941

1003

Registration District No. **791**

Primary Registration District 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: **Homer G Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo 19 das**
(Specify whether years, months or days) **39 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St Louis** (If outside city or town limits, write "RURAL") **11 17**
(d) Street No. **3927 West Belle** (If rural, give location) **1**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **12**
year **1941** hour **5:40** minute _____ P.M.
21. I hereby certify that I attended the deceased from **July 23** 19**41** to **Sept 12** 19**41**
that I last saw **her** alive on **Sept 12** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of Breast (Lt) c Metastasis**
Due to _____
Due to _____
Other conditions: **Pleural Effusion**
(Include pregnancy within 3 months of death)

Duration **1 yr**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Gertrude Williams**

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

4. Sex **female** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **January**, **19**, **1883**
(Month) (Day) (Year)

8. AGE: Years **58** Months **8** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace: **Frankfort, Ky**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Rob Jones**
13. Birthplace **Kentucky**
14. Maiden name **Mattie Fatuige**
15. Birthplace **Kentucky**

16. (a) Informant **Mattie Daniels Pullen**
(b) Address **3927 W. Belle Pl.**

17. (a) **Burial** (b) Date thereof **9/17/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Lement Cox H.**
(b) Address **2629-31 Cole Street**

19. (a) **9-11-41** (b) **J. Bredsch**
(Date received local registrar) (Registrar's signature)

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? _____

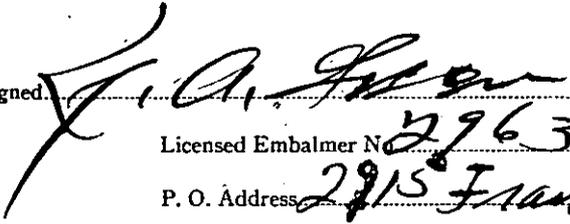
While at work _____ (Specify type of place) (e) Means of injury
23. Signature **M.E. Fowler** (M. D. or other) _____
Address **2601 N Whittier** Date signed **9-15-41**

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

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, 
Licensed Embalmer No. 2963
P. O. Address 2815 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, fact should be so stated above.