

FILED OCT 22 1943
 Registration District No. **318**

Primary Registration District No. **1003**

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:
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. 8 days**
 In this community **23 years**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Bettie Cleveland**
 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 **Married**
 6. (b) Name of husband or wife **Henry** 6. (c) Age of husband or wife if alive **74** years
 7. Birth date of deceased **Dec 1st 1869**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 10 10 hr. min.

9. Birthplace **Springville Tenn**
 (City, town, or county) (State or foreign country)

10. Usual occupation **nil**

11. Industry or business _____

12. Name **Silas Ross**

13. Birthplace **Holley Springs Miss**
 (City, town, or county) (State or foreign country)

14. Maiden name **Rachel**

15. Birthplace **Springville Tenn**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Phillie Johnson**

(b) Address **1412 1/2 N. 18th Street**

17. (a) **Burial** (b) Date thereof **10-15-43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. H. Redel & Son**
 (b) **3/33 Bell Ave**

19. (a) **OCT 13 1943** (b) **J. H. Redel**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **000 17**
 (c) City or town **St. Louis,** (If outside city or town limits, write "RURAL") **991**
 (d) Street No. **3040 Bell Avenue** (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country **0**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **October** day **11**,
 year **1943** hour **4** minute **05 a.** M.
 21. I hereby certify that I attended the deceased from **September 3,**
1943 to **October 11,** 19 **43**
 that I last saw her alive on **October 11,** 19 **43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertension**
 Duration **Unk.**

Due to **102**

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
 Of operations _____
 Of autopsy _____
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **J. E. Smith** (M. D. or other) _____
 Address **2601 W. North St.** Date signed **10/14/43**

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.....

P. O. Address.....

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.