

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12598

FILED MAY 9 1944
318

State File No.

Registration District No. Primary Registration District No. **1003**

Registrar's No. **3864**

1. PLACE OF DEATH:
(a) County: ..
(b) City or town: **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **12 days**
(Specify whether
In this community: **40 years**
years, months or days)

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") **17**
(d) Street No.: **615 N. Ewing** (If rural, give location) **9**
(e) Citizen of foreign country? (Yes or No) **21**
If yes, name country: **0**

3. (a) PRINT FULL NAME: **Agnes Bryant**
3. (b) If veteran, name war: .. 3. (c) Social Security No.

4. Sex: **Female** 5. Color or race: **3 Colored** 6. (a) Single, widowed, married, divorced: **3 Divorced**
6. (b) Name of husband or wife: .. 6. (c) Age of husband or wife if alive: .. years

7. Birth date of deceased: **Unknown**
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
about 83 hr. min.

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

10. Usual occupation: **nil**

11. Industry or business: ..

MOTHER FATHER
12. Name: **Unknown**
13. Birthplace: **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name: **Unknown**
15. Birthplace: **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Shirley M. Smith**
(b) Address: **2601 N. Whittier**

17. (a) **Burial** (b) Date thereof: **4 27 44**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director: **R. L. Bell and Co**

(b) Address: **2601 N. Whittier**

19. (a) **APR 26 1944** (b) **J. F. Budzek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **22,**
year **1944** hour **6** minute **30 P.** M.
21. I hereby certify that I attended the deceased from **April**
10, 19 **44,** to **April 22,** 19 **44.**
that I last saw her alive on **April 22,** 19 **44.**
and that death occurred on the date and hour stated above.

Immediate cause of death
Chr. Myocarditis with Cardiac decompensation

Due to: ..
Due to: ..

Other conditions: **93**
(Include pregnancy within 3 months of death)

PHYSICIAN
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) (e) Means of injury: **0**

23. Signature: **John W. ...** (M. D. or other) **124/44**
Address: **2601 N. Whittier** Date signed: **124/44**

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

AD Richardson

Licensed Embalmer No. *2928*

P. O. Address. *2625 Glasgow*

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.