DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1944

818

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19693

Registration District No. 1003

Primary Registration District No.

Registrar's No. 5761

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 St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 97 days (Specify whether years, months or days)

In this community 3 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 938a Hickory Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME OMER LEE FLOWERS

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April (Month) 14 (Day) 1906 (Year)

8. AGE: Years 38 Months 2 Days 7 If less than one day hr. 0 min.

9. Birthplace Redford (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name William Flowers
13. Birthplace Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Fanny Black
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant James Flowers
(b) Address 3002 St. Vincent

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/44 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 9301 Lafayette

19. (a) JUN 27 1944 (Date received local registrar) J. J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1944 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from March 17, 1944, to June 21, 1944, that I last saw her alive on June 21, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure — Duration

Due to Rheumatic Valvular Disease Aortic Stenosis

Due to

Other conditions Pneumonia & Other Systemic Diseases
(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) 6/23/44

Address 1515 Lafayette Ave. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

5761

5761

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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.