

No. 2
DM-8-43
5-17-39
X37823

26091

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 21 1944 318

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 2111

1. PLACE OF DEATH:
 (a) County: St. Louis, Missouri
 (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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 mos. 12 days
(Specify whether years, months or days)
 In this community 36 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 17
 (c) City or town St. Louis,
(If outside city or town limits, write "RURAL") 21
 (d) Street No. 2118 O'Fallon
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Beatrice Boyd Cardio-vase
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 355-20-1040

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 11,
 year 1944 hour 2 minute 35 A. M.

4. Sex Female 5. Color or race Negro
 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 Feb. 9, 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 19, 1944 to August 11, 1944; that I last saw her alive on August 11, 1944; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
44 6 2 hr. _____ min.

Immediate cause of death: Hypertensive Cardio-vascular disease with congestive heart failure
 Duration Unk.

9. Birthplace Whiteville Tenn. /
(City, town, or county) (State or foreign country)

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation Maid

11. Industry or business _____
 MOTHER FATHER { 12. Name Frank Boyd
 13. Birthplace Whiteville Tenn. /
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Wilson
 15. Birthplace Whiteville Tenn. /
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant James Boyd
 (b) Address 2118 O Fallon St,

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Burial (b) Date thereof Aug. 16, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Washington Park
 18. (a) Signature of funeral director Dement & Son
 (b) Address 2629-31 Cole Street

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

19. (a) Aug 13 1944 (b) J. F. Bresek
(Date received local registrar) (Registrar's signature)

23. Signature Alva Moore (M. D. or other) _____
 Address Abbeville Date signed 8/11/44

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

NOV 19 1958

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 W. C. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.