

V. S. No. 2
 OM-8-43
 ev. 5-17-39
 I X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **26189**
7284 ✓
 Registrar's No. _____

FILED SEP 8 1944 318

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:
Isolation Hospital 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5-22-44 to 8-18-44
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. 1500 Singleton
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Jessie Herron Dupree,
 3. (b) If veteran _____ name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 18
 year 1944 hour 11 minute 15 A.M.
 21. I hereby certify that I attended the deceased from 5-22
1944 to 8-18-1944
 that I last saw h. EXL alive on Aug - 18
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 1926
(Month) (Day) (Year)

Immediate cause of death
Tuberculous meningitis
1/3
 Due to _____
 Due to _____
 Other conditions Tuberculous enteritis
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
18 4 15 hr. _____ min.

9. Birthplace Tennessee 1
(City, town, or county) (State or foreign country)
 10. Usual occupation Laundress
 11. Industry or business _____

Major findings:
 Of operations _____
 Of autopsy (As above)
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name William Herron
 13. Birthplace Tennessee 1
(City, town, or county) (State or foreign country)
 14. Maiden name Mable Ann Carter
 15. Birthplace Tennessee 1
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (c) 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)
 Means of injury 0

16. (a) Informant Henniella Buchanan
 (b) Address Isolation Hospital
 17. (a) Burial (b) Date thereof 8-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood
 18. (a) Signature of funeral director Mary Wade
 (b) Address 4222 E. Fidelity Ave
 19. (a) AUG 22, 1944 J. D. Bradeck
(Date received local registrar) (Registrar's signature)

23. Signature Francis M. Lave (M. D. or other)
 Address 5300 Arsenal Date signed 8-21-44

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.....

Not embalmed Registered Apprentice No.....
working under my personal supervision.

Signed *Mary Wade and C*

By 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.