

FILED APR 23 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3072

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

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 G. Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days  
(Specify whether

In this community 41 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED

(a) State Missouri (b) County St. Louis

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

(d) Street No. 6229 Suburban  
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Hattie Shovey

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31, year 1945 hour 5 minute 40 A.M.

21. I hereby certify that I attended the deceased from March 14, 1945 to March 31, 1945

that I last saw her alive on March 31, 1945; and that death occurred on the date and hour stated above.

4. Sex Female About 70 years of age

5. Color or race Colored

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

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

7. Birth date of deceased Not known  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of the Liver with Cirrhosis Unk.

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years About 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings: Of operations \_\_\_\_\_

Of autopsy Same as above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace Senniob Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Edward Hibbler

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

14. Maiden name Miss.

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Mollie Morris

(b) Address 6229 Suburban Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 6 45  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Co., A. L. Beal Und Co.

18. (a) Signature of funeral director 2726 Lucas Ave.

(b) Address \_\_\_\_\_

19. (a) APR 6 1945 (Date received local registrar)

J. F. Bredich (Registrar's signature)

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 B. J. Murphy (M. D. or other) \_\_\_\_\_

Address do. Suburban Date signed 4/6/45

APR 27 1945

**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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address. 1154 Bayard St

**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.**