

FILED MAY 12 1945
Registration District No. 818

Primary 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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Fleecy Stevens

3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Americus Stevens
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 12 1892
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 22
If less than one day hr. min.

9. Birthplace Lake County Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Cook

11. Industry or business _____

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

16. (a) Informant Jamie Stevens
(b) Address 3608 West Pine Blvd.

17. (a) Removal (b) Date thereof 5-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cairo, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 4 1945 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 096
(c) City or town St. Louis 119
(If outside city or town limits, write "RURAL")
(d) Street No. 3824 Lindell Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
year 1945 hour 11:45 minute 12 01A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis following gunshot wound of neck inflicted at all parts of one neck stroke in the home Duration _____
3618 W. Olive Blvd. Memphis 1945
around 7:40 P.M.

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Note PHYSICIAN _____
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) Accidental
(b) Date of occurrence March 5, 1945
(c) Where did injury occur? At home in
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Yes

While at work? _____ (Specify type of place)
(e) Means of injury as above
23. Signature Dr. Alfred Perry Dep. Cor. (M. D. or other)
Address 1506 Clark Date signed 5-4-45

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.....

D. W. Wilkinson

Licensed Embalmer No..... *3576*

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.