

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 21 1945
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7984

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:
City Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 Hours.
(Specify whether _____)

In this community _____
years, months or days

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. 4420 Ohio Ave.,
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME NELLIE ADAMS.

3. (b) If veteran, name war none.

3. (c) Social Security No. none.

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept, day 11th,
year 1945. hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Female. 5. Color or race White.

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

6. (b) Name of husband or wife Fred E. Adams. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Unknown.
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Bentons; Ulcers and perforation of gall bladder

Due to _____

Due to _____

Other conditions: 127-6-11
(Include pregnancy within 3 months of death)

8. AGE:

Years	Months	Days	If less than one day
<u>74 or more.</u>			_____ hr. _____ min.

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10. Usual occupation At Home.

11. Industry or business _____

12. Name Judge Wickersham.

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

14. Maiden name Unknown.

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

16. (a) Informant M. E. Ramsey.

(b) Address 700 So. 3rd, Street.

17. (a) Removal. (b) Date thereof 9/14/45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Black Rock, Ark.,

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? _____

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) SEP 12 1945 (b) _____
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____

(e) Means of injury White at work?

23. Signature Patricia E. Raylor (M. or other) _____
Address 1300 Clark Date signed 9-17-45.

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

MOTHER FATHER

465-

DEC 18 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.....

Broford A. Miles

Licensed Embalmer No..... *2901*

-P. O. Address..... *University City*

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.