V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 10 1945

State File No. 32433

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9342

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

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1. PLACE OF DEATH:

(a) County
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (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 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3153 Evans 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Alberta Tate

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 3

5. Color or race C

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

6. (b) Name of husband or wife James Date

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Jan (Month) 5 (Day) 1894 (Year)

8. AGE: Years 51 Months 9 Days 21 If less than one day hr. min.

9. Birthplace Washington (City, town, or county) Ga. (State or foreign country)

10. Usual occupation Maid

11. Industry or business Hotel

FATHER
12. Name Condis Lyons
13. Birthplace Washington (City, town, or county) Ga. (State or foreign country)

MOTHER
14. Maiden name Rebecca Comps
15. Birthplace Washington (City, town, or county) Ga. (State or foreign country)

16. (a) Informant James Tate
(b) Address 3153 Evans ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Pk

18. (a) Signature of funeral director A. F. Walton
(b) Address 2707 Staddard

19. (a) OCT 29 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
year 1945 hour 6 minute 10 A M.

21. I hereby certify that I attended the deceased from 10-22, 1945, to 10-26, 1945; that I last saw her alive on 10-26, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Glomerulonephritis with Uremia	Unk
Due to	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No

PHYSICIAN
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)
(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 W. B. Bernard (M. D. or other)
Address 2601 N. Whittier Date signed 10-27-45

(Licensed Embalmer's Statement on Reverse Side)

Embalmer separate cert to be filed

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.....

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.