

No. 2
M-5-43
5-17-39
X3687

FILED AUG 29 1946
318

Registration District No. Primary Registration District No. 1003

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 00
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6105 Pennsylvania
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Emma Anderson

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

4. Sex Female 3. 5. Color or race Col 6. (a) Single, widowed, married, divorced Wid. 2
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Not known
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 86 hr. min.

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

10. Usual occupation Housework

11. Industry or business.....

MOTHER FATHER { 12. Name Unknown 9
13. Birthplace " (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant C. C. Black, Son

(b) Address 6105 Pennsylvania

17. (a) Burial (b) Date thereof 8-22-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coffeyville, Ark.

18. (a) Signature of funeral director C. Young

(b) Address 2620

19. (a) AUG 29 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18
year 1946 hour 4 minute 15 A M.

21. I hereby certify that I attended the deceased from 8-8 to 8-18 1946
that I last saw or alive on August 18 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration Undet.

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?

While at work? (Specify type of place).....
(e) Means of injury 0
23. Signature E. B. Williams (M. D. or other)
Address 2601 N. Whittier Date signed 8/19/46

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

272037

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 Edna Young
Licensed Embalmer No. 3371
P. O. Address St. Johns

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.