

FILED AUG 29 1946
318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**

(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 **0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **7 days**
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis** **22/17**
(If outside city or town limits, write "RURAL")

(d) Street No. **2340 Market St** **90**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mary Black**

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

4. Sex **Female** ⁰⁰¹ 5. Color or race **Col**

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

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

7. Birth date of deceased **Jan 24 1904**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
42	6	25	hr. _____ min.

9. Birthplace **Missouri** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

MOTHER FATHER { 12. Name **Ruben White** **9**

13. Birthplace **Unk** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Ida Short**

15. Birthplace **Unk** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sagin Black**

(b) Address **2340 Market St**

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

(c) Place: burial or cremation **cardinal**

18. (a) Signature of funeral director **E. Young**

(b) Address **2601 N. Whittier**

19. (a) **AUG 23 1946** (b) **J. J. Proctor**
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19**
year **1946** hour **6** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **8-12** 19 **46** to **8-19** 19 **46**
that I last saw her **er** alive on **August 19** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia** **✓** Duration

Due to _____

Due to _____

Other conditions **Retropharyngeal Abscess -ruptured**
(Include pregnancy within 3 months of death)

Cause not determined

Major findings: **Of operations**

Of autopsy **Yes**

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)

(b) Means of injury **0**

23. Signature **E. B. Williams** (M. D. or other) **0**

Address **2601 N. Whittier** Date signed **8/20/46**

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

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.