

FILED 31824 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 31617
Registrar's No. 7914

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County Saint Louis
(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 G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 days
(Specify whether years, months or days) 21 years

3. (a) PRINT FULL NAME Marie Byers

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

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

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 1866 years

7. Birth date of deceased June 1, 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 10 If less than one day hr. min.

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

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER { 12. Name Rubin Dudley

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

14. Maiden name Narcissus Dudley

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

16. (a) Informant James Byers

(b) Address 2613 P Franklin

17. (a) Burial (b) Date thereof 9/14/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director G. Carver M. Houston

(b) Address 2612 Thomas
(c) SEP 13 1946 (Date received local registrar)

19. (a) J. F. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 21000
(c) City or town Saint Louis
2829 Lucas (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 93
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11
year 1946 hour 6 minute A M.

21. I hereby certify that I attended the deceased from 8-15 1946, to 9-11 1946.
that I last saw er alive on Sept. 11 1946.
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardio vascular Disease
Duration Unk

Due to 93^d

Due to

Other conditions Pr. P. Carcinoma of the stomach
(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 0

23. Signature E. P. Williams (M. D.)
Address 2601 N Whittier Date signed 9/13/46

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Oct
Registrar's No. 7964

Registration District No. 318

Primary Registration District No. 7003

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:.....
(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 mail Ryan

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced single

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

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

8. AGE: Years 80 Months 3 Days 1 (if less than one day) hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b) J. J. Brebeck (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 08 year 1946 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

OCT 15 1946

SEE CAPTIONED BACK IN MAKE A PERMANENT RECORD

31017