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5-17-39  
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34892

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

**FILED** **OCT 16 1946** **STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8503**

**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 25 Days 2 Hrs. 13 Mins.  
(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. 1425 Cass  
(If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Shirley Jean Alfred

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. (1)

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

7. Birth date of deceased 9 9 46  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>23</u>	<u>2</u> hr. <u>13</u> min.

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Lenzo Alfred

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

14. Maiden name Marjorie Milton

15. Birthplace Ashville, North Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Duval

(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof 10-3-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director W. Johnson & Son

(b) Address 2915 Franklin Ave.

19. (a) OCT 3 1946 (b) J. F. Bredner  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 10 day 2  
year 1946 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from 5:02 P. M.  
9 - 9 19 46 to 7:15 A. M. 10 - 2 19 46  
that I last saw h. er alive on 10 - 2 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_

23. Signature Theodore Blevins (D. M. MUM)  
Address 2601 N. Whittier Date signed 10-3-46

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

33714

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**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

*J. G. Green*

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

**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.**