

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

35197

State File No.

9356

FILED NOV 12 1946

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis - Mo.  
(b) City or town St. Louis - Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Marys Infirmary  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 6 yrs. years, months or days)

3. (a) PRINT FULL NAME

Cleona Hart

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 Married  
6. (b) Name of husband or wife Millard Hart  
6. (c) Age of husband or wife if alive 37 years  
7. Birth date of deceased Jan. 26 1917  
(Month) (Day) (Year)

8. AGE: Years 29 Months 9 Days 3  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

12. Name James Ayers

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

14. Maiden name Rachel Vinson

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

16. (a) Informant Millard Hart

(b) Address 4570 St. Ferdinand

17. (a) Burial (b) Date thereof 11-2-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Manuel

(b) Address 4059 Finney

19. (a) NOV 1 1946 (b) J. J. Bradeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4570 St. Ferdinand  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 29  
year 46 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from 9.24.1946  
to 10.28  
that I last saw her alive on 10.28  
and that death occurred on the date and hour stated above.

Immediate cause of death uremia  
Duration 3 days

Due to nephrosis and hypoproteinemia

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

Major findings of operations Operated for T.O. Abscess 10.5.46  
Of autopsy Tubo-ovarian

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? J. R. Barrett M.D. (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature J. R. Barrett (M. D. or other) \_\_\_\_\_  
Address 28350 Easton Ave Date signed 10.31.46

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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.....

*Embl. Cert. filed separately.*

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.**