

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35712
State File No. 8673

FILED SEP 21 1946
Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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

1. PLACE OF DEATH:
(a) County ST. LOUIS
(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:
BARNARD FREE SKIN AND CANCER HOSP.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 0
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME FRANCES E. WHITE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife D. W. WHITE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased NOV. 19 1892
(Month) (Day) (Year)

8. AGE: Years 153 ~~57~~ Months 18 Days 18 If less than one day hr. _____ min.

9. Birthplace Jonesboro LOUISIANA
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

11. Industry or business _____
12. Name W. B. FREEMAN
13. Birthplace JONES BORO LA. |
(City, town, or county) (State or foreign country)
14. Maiden name AMANDA OTT
15. Birthplace JONES BORO LA. |
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Casey
(b) Address 4013 Cottage
17. (a) Burial (b) Date thereof 10/9/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jonesboro La
18. (a) Signature of funeral director J. F. Bredet
(b) Address 2849 No. Euclid
19. (a) OCT 9 1946 (Date received local registrar) J. F. Bredet (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4013 Cottage
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month oct day 7
year 46 hour 9 minute 40 P.M.
21. I hereby certify that I attended the deceased from July 8th 1946 to Oct 7th 1946
that I last saw h. ev. alive on 7 Oct 1946
and that death occurred on the date and hour stated above
Immediate cause of death Cardiac failure
Duration _____

Due to Coronary atherosclerosis
mitral stenosis
hypertension
Abscess Neck
Other conditions Diabetes
(Include pregnancy within 3 months of death)
Major findings: Coronary of lip e
Of operations Metastatic cancer neck
Of autopsy Not performed
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)
Means of injury _____
Signature of Physician W. H. Kelly (M. D. or other)
Address Barrington Inn St. Date signed 10/4/46

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.....

Robert L. Brunkma
.....
Licensed Embalmer No. *3553*.....

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.