

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 16 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38339
State File No. _____
Registrar's No. **10405**

Registration District No. **318**

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 month**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Maggie Anderson**

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 **wid.**

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

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

8. AGE: Years **abt - 80** Months **?** Days **?** If less than one day hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Not known**

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

14. Maiden name **Not known**

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

16. (a) Informant **Elizabeth Rhodes**

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

17. (a) **Anatomical Board** (b) Date of proof **11-9-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **W. Richter**

(b) Address **3500 Rector St.**

19. (a) **DEC 5** (b) **J.F. Bredok**
(Date received local registration) (Registrar's signature)

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. **11 N Garrison**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **4**
year **1946** hour **2** minute **50 P** M.

21. I hereby certify that I attended the deceased from **10-6-** 19**46**, to **11-4-** 19**46**, that I last saw her alive on **Nov. 4**, 19**46**, and that death occurred on the date and hour stated above.

Immediate cause of death **Senility** Duration **Unk**

Due to _____

Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **None**

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 **H. J. Erwin** (M. D. or other) _____

Address **2601 N Whittier** Date signed **11/6/46**

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.