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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1947
318

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

State File No. **3066**
Registrar's No. **892**

Registration District No. _____ Primary Registration District No. _____

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 1/2 Months
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Garnetha Sanders
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Female **5. Color or race** Col
6. (a) Single, widowed, married, divorced wid.
6. (b) Name of husband or wife Not known **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased April 1 1900
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 9 17 hr. min.

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

10. Usual occupation Housework

11. Industry or business _____

12. Name George Washington

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

14. Maiden name Lizzie Anderson
(City, town, or county) (State or foreign country)

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

16. (a) Informant Lizzie Anderson
(b) Address 2019 Cole St

17. (a) Burial, cremation, or removal Phil Phillips **(b) Date interred** Jan 21 - 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Phil Phillips

18. (a) Signature of funeral director Wm. Kelly
(b) Address 5812 East St

19. (a) JAN 27 1947 (b) St. Louis
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County o-cc
(c) City or town St. Louis 2117
(If outside city or town limits, write "RURAL") 9
(d) Street No. 2019 Cole St
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18
year 1947 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from 11-28, 1946 to 1-18, 1947;
that I last saw her alive on Jan. 18, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Peritonitis - Generalized
Fellogian Tube - Carcinoma

Duration
Undet.
"

Due to _____
Due to _____

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

Major findings: _____
Of operations _____

Of autopsy Yes

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 _____

23. Signature Clayton Hancock (M. D. or other) 0
Address 2601 Whittier Date signed 1/23/47

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.....

Thomas J. Gaudin

Licensed Embalmer No. *4293*

P. O. Address *227 E. 1st St.
St. Louis, Mo. 63102*

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.