

No. 2
-12-45
-17-39
I X47020

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6007

State File No. _____

FILED MAR 11 1947 318

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 1955

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 2 days (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. 4318 N Market
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23
year 1947 hour 8 minute 30 A. M.
21. I hereby certify that I attended the deceased from
2-21, 19 47 to 2-23, 19 47,
that I last saw h er, alive on Feb. 23, 19 47,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular Accident Duration Undet.

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy No
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)
(c) Means of injury _____
23. Signature Edw. P. Williams (M. D. or other) _____
Address 2601 N Whittier Date signed 2/24/47

3. (a) PRINT FULL NAME LOTTIE BELL

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. 2

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

7. Birth date of deceased Sept 11 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 5 12 hr. min.

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

10. Usual occupation Unk

11. Industry or business _____

12. Name Jack Brown

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

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

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

16. (a) Informant Richard Thomas

(b) Address 4318 N Market

17. (a) Burial (b) Date thereof 2-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Walter

(b) Address 2707 Standard St

19. (a) FEB 26 1947 (b) J. P. Prudeck
(Date received local report) (Registrar's signature)

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Arthur L. Heilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard

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.