

S. No. 1
OM-2-1-3
v. 5-17-39
I X32697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6027

State File No. _____

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

20
17
9

FILED FEB 17 1947 318

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 1241

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 Jewish Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 4 hours
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison 999

(c) City or town Venice
(If outside city or town limits, write "RURAL")

(d) Street No. 1212 Calhoun
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 2

If yes, name country _____

3. (a) PRINT FULL NAME Donna Jean Black

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased November 28, 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name William L. Black

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

14. Maiden name Jewell Fair

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

16. (a) Informant William L. Black

(b) Address Venice, Illinois

17. (a) Rem. to Madison (b) Date thereof Feb. 6, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Granite City, Illinois

18. (a) Signature of funeral director [Signature]

(b) Address Madison, Illinois

19. (a) FEB 6 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2/5/47 day _____
year _____ hour 11:20 PM minute _____ M. _____

21. I hereby certify that I attended the deceased from 2/5/47 to 2/5/47, 19____, to 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Brachygonitumana Primary

Due to _____

Due to _____

Other conditions 109
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy _____

Duration

1 week

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 0

23. Signature [Signature] (M. D. or other) _____

Address Jewish Hospital Date signed 2-6-47

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.