

No. 2  
-12-45  
5-17-39  
I X47074

FILED MAR 3 1947 **318**

**1003**

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 **0**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

In this community 20 YEARS  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Flossie Boyd

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female **3** 5. Color or race Col

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

6. (b) Name of husband or wife Henry Boyd 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 11<sup>th</sup> 1904  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>43</u>	<u>0</u>	<u>8</u>	hr. _____ min. _____

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

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Steve Richardson

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

14. Maiden name MATTIE RICHARDSON

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

16. (a) Informant Henry Boyd

(b) Address 2719 TAYLOR

17. (a) Burial (b) Date thereof 2 24 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK CEM

18. (a) Signature of funeral director BOYD BROS FNN. HOME

(b) Address 3204 FINNEY

19. (a) FEB 21 1947 (Date received local registrar) J. F. Brebeck (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000

(c) City or town St. Louis **1117**  
(If outside city or town limits, write "RURAL")

(d) Street No. 2719 Taylor Ave **90**  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 19  
year 1947 hour 10 minute 5 A.M.

21. I hereby certify that I attended the deceased from 2-16, 1947, to 2-19, 1947, that I last saw her alive on Feb. 19, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension - Malignant

Duration Undet.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Uremia **132**  
(Include pregnancy within 3 months of death)

Duration Undet.

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) (z) Means of injury 0

23. Signature G. B. Williams (M. D. or other) **0**  
Address 2601 N Whittier Date signed 2/20/47

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

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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

*Severin Dawson*

Licensed Embalmer No. *4371*

P. O. Address *Shaw's Mo.*

*Betnie Lopez #469*

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.