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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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

State File No. _____
Registrar's No. **1731**

FILED MAR 3 1947
318

Registration District No. _____ Primary Registration District No. _____

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 1 days (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Veleria West

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 divorced

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

7. Birth date of deceased May 16th 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 9 0 hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER

12. Name Steward West

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

14. Maiden name Elizabeth Anderson

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

16. (a) Informant Steward West

(b) Address 4394a St. Louis Avenue

17. (a) Burial (b) Date thereof 2/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetary

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

19. (a) FEB 19 1947 (b) J. F. Breuch
(Date received local registrar) (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. 4394 St. Louis Avenue
(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 16
year 1947 hour 10 minute 55 A. M.

21. I hereby certify that I attended the deceased from 2-15-47, 1947, to 2-16, 1947,
that I last saw her alive on Feb. 16, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Sickle Cell Anemia 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 plant) (c) Means of injury _____

23. Signature Theodore Berina (M.D. or other) _____

Address 2601 N Whittier Date signed 2/17/47

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.....

.....John K. Cunningham....., Registered Apprentice No. 452
working under my personal supervision.

Signed.....Thos J. Bates.....

Licensed Embalmer No. 4259

P. O. Address.....4107 Finney Avenue.....

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.