ARTMENT OF COMMERCE
BUREAU OF THE CENSUS

LED MAR 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 7367

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 378

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

**1. PLACE OF DEATH:**

County ST. LOUIS

City or town St. Louis MO (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL KOCH MO (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 93 DAYS (Specify whether

In this community 26 YEARS years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 4065 ENRIGHT AVE. (If rural, give location) 9

(e) Citizen of foreign country? NO (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME DELONEY MARY KATHLEEN

3. (b) If veteran, name war NO

3. (c) Social Security No. 368-12-5447

4. Sex FEMALE

5. Color or race COLORED

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 4 (Month) - 2 (Day) - 1905 (Year)

8. AGE: Years 41 Months 10 Days 18 If less than one day hr. min.

9. Birthplace MINERAL SPRINGS (City, town, or county) ARKANSAS (State or foreign country)

10. Usual occupation MAID

11. Industry or business

FATHER
12. Name ADOLPHUS DELONEY
13. Birthplace WICHITA (City, town, or county) KANSAS (State or foreign country)

MOTHER
14. Maiden name ALICE FOUCE
15. Birthplace KANSAS CITY (City, town, or county) MO. (State or foreign country)

16. (a) Informant ROBERT KOCH HOSPITAL RECORD

(b) Address KOCH, MO.

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

(c) Place: burial or cremation HOPPE ARKANSAS

18. (a) Signature of funeral director Bennie Love

(b) Address 3103 WASHINGTON AVE

19. (a) 2-22-47 (Date received local registrar) (b) Ruth I. Allen M.D. (Registrar's signature) BC

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month FEB day 20 year 1947 hour 5:40 minute A M.

21. I hereby certify that I attended the deceased from 11-19, 1946, to 2-20, 1947; that I last saw her alive on 2-19, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis Tuberculosis Laryngitis — Duration: about 2 years

Due to: Tuberculous ulcer of tongue

Due to: 13B

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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? (Specify type of place) 0

While at work? (e) Means of injury

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

Address Koch Mo Date signed 2-20-47

(Licensed Embalmer's Statement on Reverse Side)

APR 9 1947

## 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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

**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.**