

No. 2
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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

10495

State File No. _____

FILED MAR 31 1947

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2816

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

(d) Length of stay: In hospital or institution 15 days
11 years (Specify whether years, months or days)

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. 4233 Easton Rear
(If rural, give location)

(e) Citizen of foreign country? N (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret Ashton

3. (b) If veteran, -- name war _____

3. (c) Social Security No. ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 13
year 1947 hour 3 minute 45 A. M.

21. I hereby certify that I attended the deceased from
Feb. 16, 1947, to Mar. 13, 1947;
that I last saw her alive on Mar. 13, 1947,
and that death occurred on the date and hour stated above.

4. Sex Female 3

5. Color or race Negro

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

6. (b) Name of husband or wife Lawrence Ashton

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

7. Birth date of deceased September 15 1894
(Month) (Day) (Year)

Immediate cause of death Broncho-pneumonia

Duration Undet.

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>5</u>	<u>28</u>	_____hr. _____min.

Due to _____

Due to _____

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

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

10. Usual occupation Housewife

Major findings:
Of operations _____

Of autopsy No

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Robert Lee

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

14. Maiden name Margaret Unknown

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

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? _____

16. (a) Informant Lucious Ashton

(b) Address 4233 Easton Avenue (rear)

17. (a) Burial (b) Date thereof 3/19/47
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 4107 Finney Avenue

19. (a) MAR 17 1947 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

23. Signature Edw. J. Williams (M. D. or other) _____
Address 2601 N Whittier Date signed 3/15/47

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

STATEMENT BY LICENSED EMBALMER

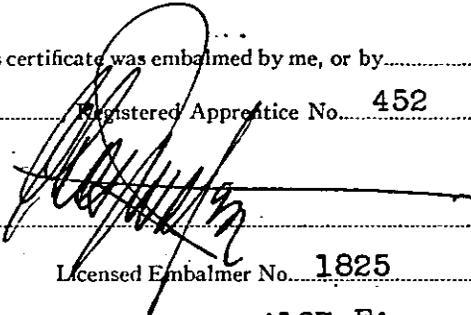
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

John K. Cunningham

Registered Apprentice No. 452

working under my personal supervision.

Signed.....


Licensed Embalmer No. 1825

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.