

S. No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11687

State File No. _____

FILED MAR 24 1947

Registrar's No. 2719

Registration District No. _____

Primary Registration District No. 1003

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

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:
HEBREW HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 WKS.
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME VERCOLO WEST

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased MAY 27 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>9</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace MEXICO Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business HOME

MOTHER FATHER {
 12. Name JOSEPH P. HAWKINS
 13. Birthplace S. CAROLINE
(City, town, or county) (State or foreign country)
 14. Maiden name FANNIE FREDMAN
 15. Birthplace S. CAROLINE
(City, town, or county) (State or foreign country)

16. (a) Informant MILDRED ROWLAND
 (b) Address 6114 WATERMAN AV.

17. (a) BURIAL (b) Date thereof 3-15-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation MEXICO, MO.

18. (a) Signature of funeral director MEEK + DICKMAN FUN. Hse.
 (b) Address 4355 WASHINGTON AV.

19. (a) MAR 14 1947 (b) _____
(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. 6114 WATERMAN AV.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 13
 year 1947 hour 12 minute 59 M.

21. I hereby certify that I attended the deceased from Feb. 2, 1947, to March 13, 1947,
 that I last saw her alive on March 12, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration 3 days

Due to Anterior poliomyelitis, Generalized Cerebral
Anterior spinal cord disease
 Due to _____

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature B. U. Glasscock (M. D. or other) M. D.
 Address 3720 Washington av. Date signed 3/14/47

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..... *John Ketter*.....

Licensed Embalmer No. *3880*.....

P. O. Address..... *St. Louis Mo.*.....

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, above space should be left blank.