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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19183

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 4904

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: ~~Missouri Pacific Train~~ 3 (If not in hospital or institution, write street number or location)

Pronounced dead at ~~[illegible]~~

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

In this community HOMER G. PHILLIPS HOSPITAL years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Chicot 999

(c) City or town Eudora 3 (If outside city or town limits, write "RURAL")

(d) Street No. NR. 0 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Mary Myrick

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 3

5. Color or race Negro

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

6. (b) Name of husband or wife Aaron Myrick

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased November (Month) 18 (Day) 1902 (Year)

8. AGE:	Years	Months	Days	If less than one day
	44	5	26	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Elijah Clark 9
13. Birthplace Unavailable (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucille Woodson
15. Birthplace Scaife, Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Aaron Myrick

(b) Address Eudora, Arkansas

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

(c) Place: burial or cremation McGhee, ~~Eudora,~~ Arkansas

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

(b) Address 4107 Finney Avenue

19. (a) MAY 15 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th year 1947 hour 8 minute 30 a.M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchi Pneumonia

Due to

Due to 10 [illegible]

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)

While at work? (e) Means of injury 3

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

Address 1300 Clark Avenue Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.