

No. 2  
-12-45  
-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 29 1947  
318

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19430  
5025  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1425 N. 22nd St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 35 yrs  
years, months or days)

3. (a) PRINT FULL NAME Nellie Thomas  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 3. Color or race CP 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 5th 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 9 10 hr. min.

9. Birthplace: Ottawa Kansas  
(City, town, or county) (State or foreign country)  
10. Usual occupation nil

11. Industry or business \_\_\_\_\_  
12. Name George Reddicks  
13. Birthplace Wks Kansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Mollie  
15. Birthplace Wks Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Thomas  
(b) Address 1425 N. 22nd St  
17. (a) burial (b) Date thereof 5-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director J. Randle & Son  
(b) Address 3133 Bell Ave  
19. (a) MAY 19 1947 J. F. Bradeck  
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1425 N. 22nd St 9  
21 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 47  
year \_\_\_\_\_ hour 6 minute 30 P. M:  
21. I hereby certify that I attended the deceased from May 3  
\_\_\_\_\_ 1947 to May 15, 1947  
that I last saw h.e.r. alive on May 15, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Renal Failure Duration 28 hr.  
Due to Congestive Heart Failure ?

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) Means of injury \_\_\_\_\_  
23. Signature M. A. Cloyd (M. D. or other) MD.  
Address 1105 1/2 N. Earhart Date signed 5-16-47

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*S. J. Watson*

Licensed Embalmer No.

*2698*

P. O. Address

*2769 Chouteau*

**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.**