

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 21 1947

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 **HOMER G. PHILLIPS HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Elizabeth I. Pickett**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **Col**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Charles Pickett**

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

7. Birth date of deceased **August 2nd 1897**
(Month) (Day) (Year)

8. AGE: Years **50** Months **-** Days **4** If less than one day hr. min.

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

10. Usual occupation **House Wife Domestic**

11. Industry or business **Monroe Williams**

12. Name **Arkansas**

13. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)

14. Maiden name **Learner James**

15. Birthplace **Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Williams**

(b) Address **1416 Cora Avenue**

17. (a) **Burial** (b) Date thereof **8/17/47**
(Burial, entombment, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green wood Cemetery**

18. (a) Signature of funeral director **John J. Hoesta**
(b) Address **2829 Washington Blvd.**

19. (a) **AUG 11 1947** (b) **J. F. Broadest**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **1014 No. Lenard Ave.**
21 (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **U.S.A.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **6th**
year **1947** hour **5** minute **30 P.** M.

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

Immediate cause of death **Heat Exhaustion**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **1947**

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **acc**

(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 **3**

23. Signature **Patrick E. Taylor, Sec. Cal** (M.D. or other)
Address **1300 Clark** Date signed **8/11-47**

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.....

J E Cooper , Registered Apprentice No. *505*
working under my personal supervision.

Signed *James D. Smith*
Licensed Embalmer No. *441*
P. O. Address. *2829 Washg*

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.