No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29464
7682

FILED AUG 21 1947

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No.

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Month (Specify whether days or months) 11 days
In this community 38 yrs (years, months or days)

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. 312 Convent St. 9
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No) -22-
If yes, name country

3. (a) PRINT FULL NAME George Rounds Jr.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Pearline
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 8 (Month) 3 (Day) 1893 (Year)
8. AGE: Years 54 Months 0 Days 8 If less than one day hr. min.
9. Birthplace Honey Comb (City, town, or county) Miss (State or foreign country)
10. Usual occupation Mixer
11. Industry or business
FATHER 12. Name George Rounds Sr
13. Birthplace Honey Comb (City, town, or county) Miss (State or foreign country)
MOTHER 14. Maiden name Francis Williams
15. Birthplace Honey Comb (City, town, or county) Miss (State or foreign country)
16. (a) Informant Pearline Jones Rounds
(b) Address 312 Convent St
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-14-47 (Month) (Day) (Year)
(c) Place: burial or cremation Green Wood Cemetery
18. (a) Signature of funeral director Gus Lowe
(b) Address 2930 Dickson St.
19. (a) AUG 13 1947 (Date received local registrar) (b) J. F. Bruecke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 11 year 1947 hour 4 minute 10 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.

Duration

Immediate cause of death Pulmonary Hemorrhage
Due to Impacted Fracture of Neck of Femur Temporarily Affected with Delirium Slipped and fell on the ice Covered Street
Due to At 1 1/2 Hour Prior to Fall
19 1947 about 7:30 PM

Other conditions (Include pregnancy within 3 months of death) Fracture never healed
Major findings of operations
Of autopsy

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Feb 19 1947 000
(c) Where did injury occur? St Louis (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)
While at work? No (e) Means of injury See Above
23. Signature (M. D. or other) 3
Address Date signed 8/13/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

AUG 13 1947

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard Ave

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.