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STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29636

FILED AUG 21 1947  
318

State File No.

7663

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oas

(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")

(d) Street No. 2938 Pine St 9  
21 (If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Merilda J. Warren

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10  
year 1947 hour 3 minute 50 A. M.

21. I hereby certify that I attended the deceased from July 30, 1947 to Aug. 10, 1947  
that I last saw her alive on Aug. 10, 1947  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Col.

6. (a) Single, widowed, married, divorced Mar. 21

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug, 5th, 1892  
(Month) (Day) (Year)

Immediate cause of death SURGICAL SHOCK Duration Undet.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Left Nephrectomy  
(include pregnancy within 3 months of death)

8. AGE: 55 Years 0 Months 5 Days If less than one day  
hr. min.

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Yes

Underline the cause to which death should be charged statistically.

9. Birthplace: Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Jane Mason

15. Birthplace ? Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant James Bell

(b) Address 2938 Pine St.

17. (a) Burial (b) Date thereof 8-14-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park  
Ellis Funeral Home

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? \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 2820 Stoddard St.

19. (a) AUG 12 1947 (Date received local registrar) J. F. Bredek (Registrar's signature)

23. Signature John B Clayton (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier St Date signed 8/11/47

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury 0

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 Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address 13

**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.**