

FILED OCT 24 1947

9378

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9378**

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: St. Louis, MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: HOMER G. PHILLIPS Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 MONTH
(Specify whether years, months or days)

In this community: 1 MONTH
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jefferson

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

Street No. 4643 Enright Ave.
(If rural, give location)

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

If yes, name country: —

3. (a) PRINT FULL NAME: STELLA G. CUNNINGHAM

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9th
year 1947 hour 8:30 minute — P. — M.

4. Sex: FEMALE

5. Color or race: Colored

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. 20, 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-13-47 to 10-9-47

that I last saw h.er. alive on Oct. 9 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Cardio-Vascular Disease with Decompensation

Duration: Undet.

8. AGE: Years 63 Months 1 Days 19 If less than one day hr. min.

Due to: —

Due to: —

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

Other conditions: Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

10. Usual occupation: Nurse - Work

Major findings: Of operations: —

11. Industry or business: Own - Home

Of autopsy: None

12. Name: Aaron Brewster

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

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

(a) Accident, suicide, or homicide (specify): —

14. Maiden name: Annice M. Munn

(b) Date of occurrence: —

15. Birthplace: Jefferson County, Mo.
(City, town, or county) (State or foreign country)

(c) Where did injury occur?: —
(City or town) (County) (State)

16. (a) Informant: Rev. Ray L. Marshall

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

(b) Address: St. James, Mo

While at work? — (Specify type of place)

17. (a) Burial (b) Date thereof: Oct 13, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Means of injury: —

(c) Place: burial or cremation: Crystal City, Mo.

23. Signature: Oscur J. Daniels (M. D. or other) —

18. (a) Signature of funeral director: Oscur J. Daniels

1) Address: 2601 N Whittier St Date signed: 10/10/47

(b) Address: Crystal City, Mo

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

MOTHER FATHER

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.....

Gentry R. Pelitte

Licensed Embalmer No. *3481*

P. O. Address *Crystal City, Mo*

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.