

FILED JUN 7 1948

318

1003

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(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 Hosp - 20
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether

In this community... years, months or days)

3. (a) PRINT FULL NAME SUNNY SCOTT

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

4. Sex Female 5. Color Negro 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive ONE 1870

7. Birth date of deceased (Month) (Day) (Year)

8. AGE Years Months Days If less than one day

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

10. Usual occupation Werk

11. Industry or business Werk

12. Name Werk

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

14. Maiden name Werk

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

16. (a) Informant Thos A. Callahan

(b) Address 300 Clark

17. (a) (Burial, cremation, or removal) Anatomical Board (b) Date thereof (Month) (Day) (Year) MAY 31 1948

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) (Date received from local registrar) MAY 31 1948 (b) (Registrar's signature) J. J. Braddock

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis, 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2908 Madison 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 22
year 1948 hour 3:40 minute any M.

21. I hereby certify that I attended the deceased from any, 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 Chronic Nephritis
Coronary Sclerosis
Other conditions W.M.A.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autops:

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)
(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) (b) Means of injury 3
23. Signature Cliffed Perry (M. D. or other)
Deputy Coroner Date signed 4/30/48

MOTHER FATHER

WRITE PLAINLY—USING UNFADING INK

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 *Ralph W. Hemmon*

Licensed Embalmer No. *3791*

P. O. Address *St. Louis, 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.