S. No. 300
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ev. 5-17-39
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WRITE PLAINLY—USE 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. 30940

FILED SEP 20 1948

Registration District No. 818 — Primary Registration District No. 1003 — Registrar's No. 7897

**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 1 month (Specify whether years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 017
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 4
(d) Street No. 4215 W Maffitt (If rural, give location) 11
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alice Daniels

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 2

5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Husband Godfrey Daniels

(c) Age of husband or wife if alive 50 years

7. Birth date of deceased April (Month) 18 (Day) 1905 (Year)

8. AGE: Years 43 Months 4 Days ~~20~~ 18 If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Rev Talley
13. Birthplace Unk MO. (City, town, or county) U (State or foreign country)

MOTHER
14. Maiden name Laura Talley
15. Birthplace Unk. MO. (City, town, or county) U (State or foreign country)

16. (a) Informant Godfrey Daniels
(b) Address 4215 W. Maffit

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-48 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Washington Park

18. (a) Signature of funeral director Boyd Bros. Fun.
(b) Address 3704 Finney Ave.

19. (a) SEP 3 1948 (Date received by local registrar) (b) J. F. Broderick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 6 year 1948 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 9, 1948 to Sept. 6, 1948 that I last saw her alive on Sept. 6, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Diabetes Mellitus; Gas Gangrene of right Leg
Due to
Due to
Other conditions Hypostatic Pneumonia (Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN — Underline the cause to 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Oscar L. Daniels M. D. or other
Address 2601 N Whitaker Date signed 9/8

(Licensed Embalmer's Statement on Reverse Side)

## 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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4548 - Reg

**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.**

LA 7664