

No. 300
-10-47
-17-39
-I 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

31616

FILED OCT 4 1948
Registration District No. 2487

Primary Registration District No. 6026

State File No. _____
Registrar No. 2163

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days 196 days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 1600a Vernon
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CORENE BOYD

3. (b) If veteran, name war _____

3. (c) Social Security No. 500-26-7832

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15
year 1948 hour 2 minute 25 p.m.

21. I hereby certify that I attended the deceased from 2-3-48, 19____, to 9-15-48, 19____;
that I last saw her alive on 9-15-48, 19____,
and that death occurred on the date and hour stated above.

4. Sex female 3 5. Color or race Negro

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

6. (b) Name of husband or wife Robert Boyd

6. (c) Age of husband or wife if alive? _____ years

7. Birth date of deceased 11 7 28
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis Duration 9 mos??

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

19 10 8 hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name Eddie Combs

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

14. Maiden name Inez Ward

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

16. (a) Informant Robert Koch Hospital records

(b) Address Koch, Mo.

17. (a) Burial (b) Date thereof 9-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St.

19. (a) 9-17-48 (b) Corene Boyd
(Date received local registrar) (Registrar signature)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy 13B

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 0

Signature Harold G. Russell (M. D. _____)

Address Robert Koch Hospital Date signed 9-15-48

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 C Culkin

Licensed Embalmer No. 4198

P. O. Address St Louis 13 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.