

FILED OCT 23 1948
Registration District No. **318**

Primary Registration District No. **6076**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Saint Louis
 (b) City or town Koch rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Robert Koch Hosp. O
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 280 days
 (Specify whether _____)
 In this community 29 years
 years, months or days)

3: (a) PRINT FULL NAME Augustus Flossie
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Licere Augustus 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: 2 6 1907
 (Month) (Day) (Year)

8. AGE: Years 41 Months 8 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation 1st overwork

11. Industry or business _____

MOTHER FATHER { 12. Name Van Hickerson
 13. Birthplace Tenn
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Anna Franks
 15. Birthplace Tenn
 (City, town, or county) (State or foreign country)

16. (a) Informant Hospital records

(b) Address Robert Koch Hosp

17. (a) Burial (b) Date thereof Oct 14 48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J W Hutchins
 (b) Address 2620 Hawthorn plod

19. (a) 10-13-48 (b) Gealby
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Saint Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 265 N. Union
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month October day 10
 year 1948 hour 3.00 minute AM
 21. I hereby certify that I attended the deceased from 9-16-47
 _____, 19____, to 10-10-, 1948
 that I last saw her alive on 10-9-, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 18 mo?

Due to _____
 Due to 136

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

Major findings:
 Of operations _____
 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? _____

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

23. Signature Bernard Friedman (M. D. or other) MD
 Address Koch Hosp, Koch Mo. Date signed 10-10-48

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 Lyda Hugger
Licensed Embalmer No. 2938
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.