

FILED DEC 2 1948 318

Registration District No. _____ Primary Registration District No. 1003

Registrar's No. 10003

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

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2706^a DELMAR!
(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 CORRIE CANNON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 3. Color or race col
5. Color or race col
6. (a) Single, widowed, married, divorced WIDOW

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

7. Birth date of deceased DEC 23 1898
(Month) (Day) (Year)

8. AGE: Years 50 Months 10 Days 22
If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSE KEEPER

11. Industry or business _____

12. Name GUS GRIFFEN

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

14. Maiden name MARtha GIBBS

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

16. (a) Informant Hazel Thomas

(b) Address 2706^a Delmar

17. (a) Supper (b) Date thereof Nov 20/48
(Date of last removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director F. A. REYN

(b) Address 4214 DELMAR

19. (a) NOV 18 1948 (b) J. B. Santa
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000
(c) City or town 2706^a Delmar 17
(If outside city or town limits, write "RURAL")
(d) Street No. St Louis mo 9
21 (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 15 year 1948 hour 6:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Oct 13-10-13, 1948, to Nov 15, 1948
that I last saw him alive on Nov 15, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis-Chronic
Bronchial Asthma

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 9/2

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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) (e) Means of injury D
Signature J. E. Jacob (M. D. or other) MD
Address 539 N. Grand Date signed 11-17

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 *Clayton W. Swann*
Licensed Embalmer No. 4580
P. O. Address 4214 Delmer Blvd

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.