

FILED DEC 2 1948 318
Registration District No.

Primary Registration District No. 1003

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community _____
(years, months or days)

3: (a) PRINT FULL NAME Alma Shipp

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex F

5. Color or race COLORED

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

6. (b) Name of husband or wife ANTHONY SHIPP

6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased OCT 1 1876
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 13
If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER { 12. Name CHAREL DAVIS

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

14. Maiden name EARLY HARPER

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

16. (a) Informant MARIE PRICE

(b) Address 3318 DELMAR ST. LOUIS MO

17. (a) BURIAL (b) Date thereof 11-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TROY MISSOURI

18. (a) Signature of funeral director Wayne M. E. Coy

(b) Address Troy Missouri

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

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. 3318 Delmar
21
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1948 hour 6 minute 35 p. m.

21. I hereby certify that I attended the deceased from Nov. 12 19 48 to Nov. 14 19 48
that I last saw her alive on Nov. 14 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy No

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)

Means of injury Stroke

23. Signature Oscar J. Daniels (M. D. or other) _____

Address 2601 N Whittier Date signed 11/15/48

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 Wayne Mc Coy
Licensed Embalmer No. 35806
P. O. Address Troy 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.