

FILED OCT 27 1950

STANDARD CERTIFICATE OF DEATH

35247
State File No. 8763
1003 Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
c. LENGTH OF STAY (In this place) 6 DAYS		d. STREET ADDRESS (If rural, give location) 1432 N. Taylor Ave. (Rear)	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) LOVELLIA	b. (Middle) FISHER	c. (Last) RAY	4. DATE OF DEATH (Month) (Day) (Year) OCT 15 1950
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5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 7	8. DATE OF BIRTH Nov 16 1897	9. AGE (In years last birthday) (Specify) 52	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Fort Adams, Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Abe Fisher	13b. MOTHER'S MAIDEN NAME Nellie Hall	14. NAME OF HUSBAND OR WIFE Dead
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Fred Ray	ADDRESS 1432 (Rear) N. Taylor Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic heart disease	DUE TO (b) _____		10 yr.
ANTECEDENT CAUSES <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	Chronic auricular fibrillation		? 5 yr.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H/6A
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22. I hereby certify that I attended the deceased from **OCT 9**, 19**50**, to **OCT 15**, 19**50**, that I last saw the deceased alive on **OCT 15**, 19**50**, and that death occurred at **3:05 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE FR Knable	(Degree or title) M.D.	23b. ADDRESS 600 S. KINGSHIGHWAY, ST. LOUIS, MO	23c. DATE SIGNED 10/15/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/21/50	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. OCT 17 1950	REGISTRAR'S SIGNATURE J B Pasater	25. FUNERAL DIRECTOR'S SIGNATURE C.W. Roberts	ADDRESS 1416 N. Taylor Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Fulton E. Culkin

Signed.....

Student Embalmer

Licensed Embalmer No. *4198*

P. O. Address *St Louis 13.0*

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.