

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D NOV 16 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33837
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003** Registered No. **8823**
 (c) City **Saint Louis** (d) Street No. **4483 West Belle Place** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **Unavailable** (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **James A. Baxter**

(a) Residence, No. **4483 West Belle Place** St. **III** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE Negro	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) Cynthia Baxter		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 25, 1868		
7. AGE YEARS 70	MONTHS 8	DAYS 12
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor		If LESS than 1 day, hrs. or min.
9. Industry or business in which work was done, as saw mill, bank, etc.		11. Total time (years) spent in this occupation Unk.
10. Date deceased last worked at this occupation (month and year) 1932		
12. BIRTHPLACE (CITY OR TOWN) Savannah (STATE OR COUNTRY) Georgia		
13. NAME Charles Baxter		
14. BIRTHPLACE (CITY OR TOWN) Unavailable (STATE OR COUNTRY) Unavailable		
15. MAIDEN NAME Rebecca Slater		
16. BIRTHPLACE (CITY OR TOWN) Savannah (STATE OR COUNTRY) Georgia		
17. INFORMANT Cynthia Baxter (ADDRESS) 4483 West Belle Place		
18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Oct. 10th 1938		
19. FUNERAL DIRECTOR (NAME) Charles J. Slater (ADDRESS) 4107 Finney Avenue		
20. FILER J. H. Bradock Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **October 7, 1938**

22. I HEREBY CERTIFY, That I attended deceased from **Oct. 7, 1938** to **October 7, 1938**
 I last saw him alive on **October 7, 1938** Death is said to have occurred on the date stated above, at **5:30 A.M.**
 The principal cause of death and related causes of importance were as follows:
Chronic Bronchopneumonia
Nephritis
 Other contributory causes of importance:
None

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) **X J. H. Bradock** M. D.
 (Address) **4 South Compton Avenue**

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,

James A. Johnson

, or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.

3522

P. O. Address 4107 Finney Avenue

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, above space should be left blank.