

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.

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

285  
Do not use this space.

REC'D FEB 10 1939

791  
1003

Registered No. 285

1. PLACE OF DEATH  
 (a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City St. Louis ..... (d) Street No. Homer Phillips Hospital ..... 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 14 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lucy Champion  
 (a) Residence, No. 1708 Belleglade 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 F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 8, 1882

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>56</u>	<u>--</u>	<u>29</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil  
 9. Industry or business in which work was done, as saw mill, bank, etc. ....  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alabama  
 13. NAME James Goldson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alabama

MOTHER  
 15. MAIDEN NAME Luise Graham  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alabama

17. INFORMANT Evelyn Hilliard (ADDRESS) 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park 1/11/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bennie Love 3103 Washington Blvd

20. FILED J. D. Beck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 7 19 39

22. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1939, to Jan. 7, 1939  
 I last saw him 6P alive on Jan. 7, 1939 Death is said to have occurred on the date stated above, at 4:30a m.  
 The principal cause of death and related causes of importance were as follows:  
Hypertensive heart disease  
Lobar pneumonia - terminal

Other contributory causes of importance:  
terminal

Name of operation ..... Date of .....  
 What test confirmed diagnosis? clinical Was there an autopsy? NO

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 N. J. Leonard, M. D.  
 (Signed) N. J. Leonard (Address) 2601 N Whittier

Date of onset 1/5/39

JAN 9 1939

**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~~ .....

William C. McDowell α, Registered Apprentice No. 156  
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

P. O. Address 3506 Franklin

**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.**