REC'D FEB 10 1939

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

765
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 765

(c) or City St. Louis (d) Street No. Homer G. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 400 Infant Calloway

(a) Residence, No. 2625 Franklin St. 21
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Undet.
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): -

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1-4-39

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis, Mo.

FATHER
13. NAME: --
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): --

MOTHER
15. MAIDEN NAME: Willie Mae Calloway
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

17. INFORMANT (ADDRESS): E W Sherard, 2601 N. Whittier St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE City Cem DATE 1-26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Ira Hamilton, City Health Dept

20. FILED JAN 25 1939 J. F. Budick, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 1-4- 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 9:40 A. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Unknown (Stillborn)	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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) J B Martin, M. D.
(Address) 2601 N. Whittier St.

(Licensed Embalmer's Statement on Reverse Side)

WHITE PLAINLY, WITH UNFADING INKLEPTHIS IS A PERMANENT RECORD

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.

1 X16605

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.