

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH

3 BUREAU OF VITAL STATISTICS 791

CERTIFICATE OF DEATH

4300

Do not use this space.

1. PLACE OF DEATH

(a) County..... Enroute City/Hospital Registration District No.
 (b) Township..... Primary Registration District No. Registered No. **993**
 (c) City..... St Louis, Mo. (d) Street No. In Pauls Homer & Phillips 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 ⁶³⁰ Leevond Word

(a) Residence, No. 2206 / Adams St. St. 22 (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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 9 1938

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 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) St Louis
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME Leon D. ckson

14. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Irene Word

16. BIRTHPLACE (CITY OR TOWN) Miss.
 (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Irene Word
2206 Adams

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE FEB 1 1939.

19. FUNERAL DIRECTOR (NAME) E. L. Garner
 (ADDRESS) 2829 Washington Ave.

20. FILED FEB 1 1939 J. P. Budek
 Local Registrar

No other contributory causes
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28 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 10:50 p.m.

The principal cause of death and related causes of importance were as follows:

Acute Bacteric Enteritis
Malnutrition

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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? no
 If so, specify Alfred W. Perry
 (Signed) Alfred W. Perry M.D.

(Address) Alfred W. Perry

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

Arthur L. Heilbard

Licensed Embalmer No.

3389 Dick

P. O. Address

3383028

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.