

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

16919  
Do not use this space.  
4458

791  
1003

1. PLACE OF DEATH <sup>550'D JUN 1 1939</sup> Phillips Hospital  
(a) County ..... / Registration District No. ....  
(b) Township ..... / Primary Registration District No. .... Registered No. ....  
(c) City St. Louis, Mo. / (d) Street No. City Hospital #2 ..... 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Sam Gates  
(a) Residence, No. 2225 Clark 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 Col. 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) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
Apparent 55

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

FATHER 13. NAME unknown  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Rosetta Jackson  
(ADDRESS) 2323 Eugenia St.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Father Dickson DATE 5/15/39 19.

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

20. FILED MAY 15 1939 J. D. Biedeck  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/6/39 19

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 6:00 P.M.  
The principal cause of death and related causes of importance were as follows:  
Pythisis Pulmonalis;  
Chronic Adhesive Pericarditis;

Other contributory causes of importance: .....

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

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 .....  
(Signed) Alfred Perry M.D.  
(Address) Deputy Coroner

THIS 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.

**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. Hoilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson

**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.**