

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.

Registration District No. 1008 Primary Registration District No. _____

1. PLACE OF DEATH: Enroute Homer Phillips
 (a) County _____ 3
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Enroute Homer Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days _____

3. (a) PRINT FULL NAME: Eddie Sellers #62
 8. (b) If veteran, name war: World's War 8. (c) Social Security No. _____

4. Sex: Male 5. Color or race: Col. 6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Unknown
 (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ If less than one day
About 43 hr. _____ min _____

9. Birthplace: Alabama
 (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation: Porter

11. Industry or business: Homer Phillips Hospital

12. Name: Pete Sellers

13. Birthplace: Alabama
 (City, town, or county) _____ (State or foreign country) _____

14. Maiden name: Mattie Rose

15. Birthplace: Alabama
 (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant's own signature: Porter Turner

(b) Address: 4308 Page Ave.

17. (a) Burial (b) Date thereof: 7-31-39
 (Burial, cremation, or removal) _____ (Month) (Day) (Year)

(c) Place: burial or cremation: National Cemetery

18. (e) Signature of funeral director: C. S. Garner

(b) Address: 2829 Washington, Ave.

19. (a) JUL 31 1939 (b) J. D. Braddock
 (Date received local registrar) _____ (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County _____
 (c) City or town: St. Louis III
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 4259 W. Finney
 (If rural, give location) _____
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26th
 year 1939 hour 7:30 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion Duration _____
Chronic Myocarditis;

Due to _____

Due to _____

Other conditions: _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____

Of autopsy: See Above

PHYSICIAN

 Underline the cause to which death should be charged etatically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury: 4

23. Signature: Alfred Perry (M. D. or other) _____

Address: Deputy Registrar Date signed: 7/31/39

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 R. Hilliard

Licensed Embalmer No. 3289

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.