

SEP 14 1939

Registration District No. 1008

Primary Registration District No. _____

Registrar's No. 7449

1. PLACE OF DEATH:

(a) County St. Louis Mo
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Unknown White Male

3. (b) If veteran, name war unk 3. (c) Social Security No. unk

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased About 1869
(Month) (Day) (Year)

8. AGE: Years abt. 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace unk (City, town, or county) (State or foreign country)

10. Usual occupation unk

11. Industry or business _____

12. Name unk

13. Birthplace unk (City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. J. Phelan

(b) Address 4431^c Rosa Ave

17. (a) _____ (b) Date thereof 8-31-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beverlyfield

18. (a) Signature of funeral director Paul Bros

(b) Address 3029 Lafayette

19. (a) AUG 30 1939 (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Miss (b) County _____
(c) City or town unk 28
(If outside city or town limits, write "RURAL")
(d) Street No. unk (If rural, give location)
(e) If foreign born, how long in U. S. unk years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17
year 1939 hour 7 minute 35 A. M.

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

Immediate cause of death Coronary Sclerosis
Chronic Interstitial Nephritis
Arterio Sclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operation _____

Of autopsy See above

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) Means of injury _____

23. Signature Alfred Perry (M. D. or other) _____
Address Deputy Coroner Date signed 8-29-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.