

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

FORM 9-19-33 I X1603

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.

SEP 14 1939

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

27976
Do not use this space.

791
1003

Registered No. 7476

1. PLACE OF DEATH

(a) County / Registration District No.
 (b) Township / Primary Registration District No.
 or St. Louis
 (c) City (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 Travis

(a) Residence, No. 3011 Clark Avenue St. 18
 (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 F 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) 6-12-1939

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) St. Louis (STATE OR COUNTRY) Mo.

FATHER 13. NAME William Travis

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

MOTHER 15. MAIDEN NAME Osseful Armstead

16. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Father Mary Sweeney
2601 N. Whittier St

18. BURIAL, CREMATION, OR REMOVAL PLACE CITY CEMETERY DATE 8-31-39

19. FUNERAL DIRECTOR (NAME) Dr. Hamilton (ADDRESS) City Health Dept

20. FILED AUG 30 1939 J. F. Brudick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-12- 19 39

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 5:35 P. M.

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

Unknown (Stillborn)

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? clinical 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?
 If so, specify
 (Signed) J. B. Martin M. D.
 (Address) 2601 N. Whittier St.

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 comply with the above constitutes grounds for revocation of license.)

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