

REC'D SEP 14 1939 791

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 7527

1003

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (c) Name of hospital or institution: City Hospital  
 (d) Length of stay: In hospital or institution 1 Day  
 In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (d) Street No. Erie House, 218 S. 4th St.  
 (e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME Bob White  
 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 unk  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 16, 1868

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 10, year 1939 hour 10:00 minute \_\_\_\_\_ P. \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from August 9, 1939 to August 10, 1939  
 that I last saw h. im alive on August 10, 1939 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>70 yrs</u>	<u>11</u>	<u>24</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of Esophagus  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Carcinoma of Esophagus  
 Of autopsy \_\_\_\_\_

9. Birthplace North Carolina  
 10. Usual occupation Nil.  
 11. Industry or business \_\_\_\_\_  
 12. Name James White  
 13. Birthplace unk  
 14. Maiden name Minnie Scottie  
 15. Birthplace unk

PHYSICIAN  
 Underline the cause to which death should be charged statistically

MOTHER FATHER  
 16. (a) Informant's own signature Ann Morrison  
 (b) Address City Hospital, 1515 Lafayette  
 17. (a) (Burial, cremation, or removal) Washington (b) Date thereof 8-23-39  
 (c) Place: burial or cremation \_\_\_\_\_  
 18. (a) Signature of funeral director W. R. Ruten  
 (b) Address 35 S. Ruten  
 19. (a) (Date received local registrar) AUG 31 1939 (b) \_\_\_\_\_

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 \_\_\_\_\_  
 23. Signature Donald J. Brant (M. D. or other) \_\_\_\_\_  
 Address City Hospital, Date written 8/23/39

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.

Rev. 5-17-39

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**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.**