

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

30149 ✓

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1589

1. PLACE OF DEATH:

(a) County 0
 (b) City or town Saint Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph's County's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. _____
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert Doss

3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-10-8475

4. Sex Male 5. Color or race Negro 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 October 1906
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>11</u>	<u>?</u>	hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business ---

12. Name Nelson Doss

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

14. Maiden name Hattie Harris

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

16. (a) Informant's own signature Nelson Doss

(b) Address 3303 a Laclede Avenue

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-9-39
 (Month) (Day) (Year)

(c) Place: burial or cremation Starksville, Miss.

18. (a) Signature of funeral director Charles J. Gaten

(b) Address 4107 Finney Avenue

19. (a) SEP 7 1939 (b) DR. Meyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town Saint Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3303 a Laclede Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
 year 1939 hour 12 minute 50 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 Accident of the Right wrist, due to striking into glass window, self
Due to (reflected) while intoxicated
Septicemia
 Other conditions 185
 (Include pregnancy within 3 months of death)

Duration
4/3/39
4/3/39

Major findings:
 Of operations _____

Of autopsy Septicemia due to
gas gangrene organisms

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence Sept 3, 1939
 (c) Where did injury occur? Robertson, Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place

While at work? No (Specify type of place) (e) Means of injury Fish truck
glass window
 (M. D. or other)

23. Signature John D. Howell
 Address Corner 62 Louis Court Date signed 9/7/39

PHYSICIAN
 Underline the cause to which death should be charged statistically

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

B.C.

(Licensed Embalmer's Statement on Reverse Side)

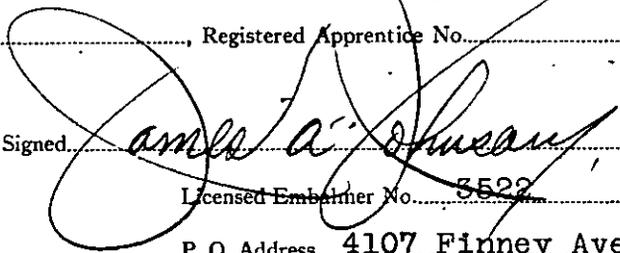
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... .....

Licensed Embalmer No..... 5522.....

P. O. Address..... 4107 Finney Avenue.....

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.