

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. **791**

Primary Registration District No. _____

Registrar's No. **7718**

1. PLACE OF DEATH: **1003**
 (a) County _____
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Homer Phillips Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Since 8/23/39**
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1905 Division** 21
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **2**
 year **1939** hour **10** minute **48** a. **M.**
 21. I hereby certify that I attended the deceased from **8/23/39**
 _____, 19____, to **9/2/39**, 19____;
 that I last saw him alive on **9/2/39**, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis** Duration **8-10 yrs**

Due to **---**
 Due to **---**

Other conditions **Senile psychosis** unknown
 (Include pregnancy within 3 months of death)

Major findings: **---**
 Of operations **---**
 Of autopsy **---**
 Underline the cause to which death should be charged statistically.

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 **H. J. Lyman** (M. D. ~~XXXX~~)
 Address **2601 N Whittier** Date signed **9/6/39**

3. (a) PRINT FULL NAME **Abe Rucker** **260**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **C** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Mrk** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **January 1, 1869**
 (Month) (Day) (Year)

8. AGE: Years **70** Months **8** Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Sinion Rucker**
 13. Birthplace **Kentucky**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Carl Smith**
 (b) Address **1905 Division**

17. (a) **BURIAL** (b) Date thereof **9-6-39**
 (Burial, cremation, or removal) (Month)-(Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Mary Wade**
 (b) Address **4202 Fremont**

19. (a) **SEP 6 1939** (b) **J. H. Brubaker**
 (Date received local registry) (Signature)

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.