

REG OCT 4 1939 791
Registration District No. **1002**

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH: 1
(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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 7/10/39
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")
(d) Street No. 3141 Rutger
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

8. (a) PRINT FULL NAME Otis Selvage
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 10
year 1939 hour 3 minute 05 P. M.

4. Sex M 5. Color or race C
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Selvage
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased April 5, 1895
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7/10/39
_____, 19____, to 9/10/39, 19____;
that I last saw him alive on 9/10/39, 19____;
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>5</u>	<u>5</u>	_____ hr. _____ min.

Immediate cause of death
Manic depressive psychosis 3 mos.
Hypostatic pneumonia - terminal 2 days
Due to Bronchial

9. Birthplace Georgia
(City, town, or county) (State or foreign country)
10. Usual occupation nil

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 107a

11. Industry or business _____
12. Name William Selvage
13. Birthplace Georgia
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Daniels
15. Birthplace Georgia
(City, town, or county) (State or foreign country)

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

MOTHER FATHER
16. (a) Informant's own signature Mary Selvage
(b) Address 2321 1/2 Spruce St
17. (a) Burial (b) Date thereof 9-16-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director W. J. Richardson
(b) Address 2626 Glasgow
19. (a) SEP 15 1939
(Date received local registrar) (Date received)

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. or other)
Address 2601 Whittier Date signed 9/13/39

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.

Signed

Richardson

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

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.