

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31210

Registrar's No. 8273

Registration District No. 1098

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(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 8/13/39
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary Brooks 670

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 12, 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 5 10 hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

12. Name Randle Gibson

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

14. Maiden name Unknown
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Sylvester Brooks

(b) Address 3117 N Lucas

17. (a) Burial (b) Date thereof 9/27/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Mary Wade

(b) Address 4202 S. Huber Ave

19. (a) SEP 27 1939 (b) J. J. [Signature]
(Date received and registered) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 21
(d) Street No. 3117 N Lucas
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22
year 1939 hour 8 minute 10 p. M.

21. I hereby certify that I attended the deceased from 8/13/39
_____, 19____, to 9/22/39, 19____;
that I last saw hER alive on 9/22/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis with hypertension Duration abt 8 yr

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

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. [Signature] (M. D. or D.D.S.)

Address 2601 N Chittie Date signed 9/25/39

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

S. Watson

Licensed Embalmer No.

2698

P. O. Address

2769 Chase

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.