

NOV 13 1939
Registration District No. 1002

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1
(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 8/26/39
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME John Westley 234
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 unk 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 1, 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER
12. Name Gus Westley
13. Birthplace Missouri
(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 [Signature]
(b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 9-18-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director W. Richter
(b) Address 3600 Ruby

19. (a) OCT 3 1939
(Date signed local health officer)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis [21]
(If outside city or town limits, write "RURAL")
(d) Street No. 2207 Chestnut
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1939 hour 6 minute 25 P. M.
21. I hereby certify that I attended the deceased from 8/26/39
_____, 19____, to 9/12/39, 19____;
that I last saw him alive on 9/12/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Aortic aneurysm abt 3 yrs
Syphilis " 35 yrs
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 8 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration
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. Lyman (M. D. or other)
Address 2601 N Whittier Date signed 9/18/39

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.....

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.