

NOV 13 1939

791

Primary Registration District No.

Registrar's No.

8666

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(c) Name of hospital or institution:
3425 Olive St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 years (Specify whether
In this community 20 years (years, months or days)

3. (a) PRINT FULL NAME

Roy Adams

3. (b) If veteran,
name war

none

3. (c) Social Security
No. Unknown4. Sex M5. Color or
race W6. (a) Single, widowed, married,
divorced M6. (b) Name of husband or wife
Nealey6. (c) Age of husband or wife if
alive 46 years

7. Birth date of deceased

May 5, 1894

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

4555

hr. min.

9. Birthplace

Missouri

(City, town, or county)

(State or foreign country)

10. Usual occupation

Carpenter

11. Industry or business

Unemp.

12. Name

Unknown

18. Birthplace

Unknown

(City, town, or county)

(State or foreign country)

14. Maiden name

Unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Nealey Adams(b) Address
Burial3425 Olive St(b) Date thereof 10/12/39

(c) Place: burial or cremation

New St. Marcus Cem

18. (a) Signature of funeral director

A. W. McLaughlin

(b) Address

2301 Lafayette Ave

19. (a)

Oct 10 1939

(Date certified local health officer)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri
(a) State (b) County 1
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 3425 Olive St
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1939 hour 3:30 minute _____ AM.

21. I hereby certify that I attended the deceased from Oct 19
_____, 1939, to _____, 19____
that I last saw him alive on Oct 9, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

cardiac failure

Duration

Due to

chr myocarditis

Due to

Other conditions

chr cholecystitis, no stones

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)

(a) Means of injury _____

23. Signature

A. F. Catanzaro (M. D. or other) _____

Address

St. Johns Hosp. Date signed Oct 10

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 L. R. Cooper

Licensed Embalmer No. 3133

P. O. Address 2317 Lafayette St

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.