DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34323

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 8861

1. PLACE OF DEATH: NOV 13 1939

(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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 days (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (18)
(If outside city or town limits, write "RURAL")

(d) Street No. 3127 Hickory
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Samethel Daniels 542

3. (b) If veteran, name war ---------

3. (c) Social Security No. ------

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April, (Month) 26 (Day) 1919 (Year)

8. AGE: Years 20 Months 5 Days 19 If less than one day hr. min.

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

10. Usual occupation Student

11. Industry or business 0

FATHER
12. Name Samuel Daniels 1
13. Birthplace Brownsville, (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name Vernella Hubberd
15. Birthplace Brownsville, (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant's own signature Vernella Hubberd
(b) Address 3127 Hickory St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ 18/39 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas J. Gates
(b) Address 4107 Finney Ave.

19. (a) OCT 18 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10- day 15
year 1939 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from 9- 12-1939, 19, to 10-15-, 1939
that I last saw her alive on 10-15-, 1939
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	2 weeks
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

108

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? (Specify type of place)
While at work (e) Means of injury

23. Signature Dean A. Smart (M. D. or other)
Address 2601 N. Whittier St. Date signed 10-17-39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 I X19511

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 James A. Johnson, Registered Apprentice No. ....., working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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.