

791 STANDARD CERTIFICATE OF DEATH

34583

State File No.

Registrar's No.

9121

Registration District No. 10008

Primary Registration District No.

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 Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2721a Eugenia
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27th
 year 1939 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____
 _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____,
 and that death occurred on the date and hour stated above.
 Immediate cause of death: Unknown (Stillborn) Duration _____

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

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____
 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 J. B. Martin (M. D. or other) _____
 Address 2601 N Whittier Date signed 10/24/39

3. (a) PRINT FULL NAME Robert Gardner 635
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: 9-26-39
 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name Robert Gardner
 13. Birthplace Birmingham, Ala.
 (City, town, or county) (State or foreign country)
 14. Maiden name Pearl Jones
 15. Birthplace Maria, Ark.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Katherine Mary Sherar
 (b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 10-26-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director John Hamilton
 (b) Address City Health Dept

19. (a) OCT 25 1939 (b) J. F. Budick
 (Date of registration) (Registrar's signature)

WHILE FILLING IN THIS FORM, PLEASE READ THE INSTRUCTIONS ON THE REVERSE SIDE. 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.

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.