

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Grisco Hospital
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Robert W. Courtney

3. (b) If veteran, name war None 3. (c) Social Security No. 702-07-676

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Callie Mai Courtney 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased August 131 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 10 If less than one day _____ min.

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

10. Usual occupation Electrician

11. Industry or business Grisco R.R.

12. Name Sam Courtney

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

14. Maiden name Married Thorne

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

16. (a) Informant's own signature Callie Mai Courtney

(b) Address 6952 1/2 Hancock

17. (a) Removal (b) Date thereof Nov. 11, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South North St. Louis

18. (a) Signature of funeral director Charles H. Nathan

(b) Address 225 Union St. St. Louis

19. (a) NOV 11 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 6952 1/2 Hancock
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11 A. M.
year 1939 hour 9 minute _____

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

Immediate cause of death Fractures of skull and
fractures of ribs due to
laceration of lung
by fractures of ribs

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

Medical findings: House of Fyler and
James Thorne doctor

Of autopsy Nov. 11 - 1939

If death was due to external causes, fill in the following:
(a) Accidental, suicide, or homicide (specify) Accidental

(b) Date of occurrence 11/11/39

(c) Where the injury occurred St. Louis
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or public place?
Industrial place
While at work _____ (Specify type of place)
(e) Means of injury Fall

22. Signature James Thorne (M. D. or other)
Address _____ Date signed 11/11/39

Duration

PHYSICIAN

Under the provisions of which death should be charged statistically

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.

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

Bernard J. Stuart
.....

Licensed Embalmer No. *3500*

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.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

37798

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 201
 (b) Township..... Primary Registration District No. 1003
 (c) City..... (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

ROBERT W. COURTNEY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF #39 702-07-6716
 SOCIAL SEC.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED 17/11/39 J.F. Brubaker

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

22. I HEREBY CERTIFY, That I attended deceased from , 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

SUPPLEMENTARY

Other contributory causes of importance:

Date of onset

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

WHILE LIVING, WITH OUPDING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

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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.