

DEC 13 1939
791
Registration District No. _____

Primary Registration District No. _____

Registrar's No. **9842**

1. PLACE OF DEATH: **1008**
(a) County 1
(b) City or town St. Louis
(c) Name of hospital or institution: Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2108 Franklin (Rear)
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Willie Fields 1.22
3. (b) If veteran, name war None
3. (c) Social Security No. 498-01-5630

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 15
year 1939 hour 1:30 minute _____ A. _____ M.
21. I hereby certify that I attended the deceased from 11-3- 1939 to 11-15- 1939
that I last saw him alive on 11-15- 1939
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Annie Fields
6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased May 4th 1907
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis
Duration About 2 yrs.

8. AGE: Years 32 Months 6 Days 10
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

10. Usual occupation Laborer

MOTHER FATHER
11. Industry or business _____
12. Name Wesley Fields
13. Birthplace ? Miss
(City, town, or county) (State or foreign country)
14. Maiden name Alice Roberts
15. Birthplace ? Miss
(City, town, or county) (State or foreign country)

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? 1 (Specify type of place) (e) Means of injury _____

16. (a) Informant's own signature Willie Fields
(b) Address 2108^a Rear Franklin Ave
17. (a) Burial (b) Date thereof 11-19-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2220 Stoddard St
19. (a) NOV 18 1939 (b) _____
(Date received local registrar) (Registrar's name)

23. Signature M. W. Allen (M. D. or other) 11-16-1939
Address 2601 N. Whittier St. Date signed _____

MARGIN RESERVED FOR BINDING
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.

FORM 5-17-39
Rev. 5-17-39
U. S. GOVERNMENT PRINTING OFFICE: 1938

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. 2963

P. O. Address. 2910 Franklin 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.

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

38003

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **701**
 (b) Township..... Primary Registration District No. **HOMER**
 or
 (c) City..... (d) Street No. **HOMER & PHILLIPS HOS 6** 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. **2108 FRANKLIN** St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SEPARATED.	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
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 11/15/39 19..... J. D. Brudeck Local Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-15-1939**

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

I last saw him 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:

Date of onset

Other contributory causes of importance:

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)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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.