

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 10173

U.S. DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS  
DEC 13 1939

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution: Homer G. Phillips Hosp.  
(d) Length of stay: \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo.  
(d) Street No. 2525 N Newstead  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

In this community, \_\_\_\_\_ years, months or days  
3. (a) PRINT FULL NAME Boyd

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 day 11  
year 1939 hour 2 minute 45 A. M.

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 11-11-39

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1939 to \_\_\_\_\_, 1939  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

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

Immediate cause of death Unknown (Stillborn)  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace St. Louis, Mo.  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name John Boyd  
13. Birthplace Miss.  
14. Maiden name Mable Anderson  
15. Birthplace Oxford, Miss.

PHYSICIAN  
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Arthur M. Sherman  
(b) Address 2601 N Whittier Street  
17. (a) Burial (b) Date thereof 11-30-39  
(c) Place: burial or cremation City Cemetery  
18. (a) Signature of funeral director Ma Hamilton  
(b) Address City Health Dept.  
19. (a) NOV 29 1939 (b) J. B. ...

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature J. B. ... (M. D. or other)  
Address 2601 N. Whittier State signed 11/25/39

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. 6-17-39  
U. S. GOVERNMENT PRINTING OFFICE

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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..**