

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(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 5Hrs. 50 Mins.
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")

(d) Street No. 2244a O'Fallon
(If rural, give location)

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

3. (a) PRINT FULL NAME Williams 452

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 11- 14- 1939
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14
year 1939 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 11/14
1939, to 11/14/39, 19____;
that I last saw her alive on 11-14, 1939,
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day
7 hr. 50 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name unknown

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

14. Maiden name Catherine Williams

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

Immediate cause of death Premature Newborn

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Edward M. Sherard

(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof 11-30-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. Hamilton

(b) Address City Health Dept.

19. (a) NOV 25 1939 (b) J. Budick
(Date received local registrar) (Registrar's signature)

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

23. Signature G. E. Pease (M. D. or other) _____
Address 2601 N. Whittier Date 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. 8-17-39

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.