

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41421

Registration District No. 1008

Primary Registration District No. _____

Registrar's No. 10544

1. PLACE OF DEATH:

(a) County 1
(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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo 18 days
(Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Hattie Cook 200

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, widow

6. (b) Name of husband or wife Eraser Cook 6. (c) Age of husband or wife if alive about 1883 years

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

8. AGE: Years Months Days If less than one day
About 56 - - hr. min.

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

10. Usual occupation unknown 9

11. Industry or business _____

MOTHER FATHER { 12. Name unknown 9

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

14. Maiden name Hanna Anderson

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

16. (a) Informant's own signature Georgia Banks

(b) Address 2944 Thomas st

17. (a) Burial (b) Date thereof 12 9 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Asubba Thomas

(b) Address 2734 Sheridan Ave

19. (a) DEC 9 1939 (b) J. F. B. B. B. B. B.
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 27
(If outside city or town limits, write "RURAL")
(d) Street No. 2944 A Thomas
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 5 day 5
year 1939 hour 12:00 minute 5 P. M.

21. I hereby certify that I attended the deceased from Oct 17, 1939, to Dec 5, 1939
that I last saw her alive on December 5, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Nephritis c Hypertension 1-2yrs

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

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: H. J. Lyman (M. D. or other)
Address 2601 N. Whittier Date signed _____

12/6/39

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 DAE

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Charles R. Howell

Licensed Embalmer No. 2452

P. O. Address ST Louis

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.