

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. 41695

Registrar's No. 10818

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 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether _____)
In this community Unknown
years, months or days

3. (a) PRINT FULL NAME Willie Clay

8. (b) If veteran, name war no 8. (c) Social Security No. 490-05-0426

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

6. (b) Name of husband or wife Lubirtha Clay 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Jan 18th 1902
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>37</u>	<u>10</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation Labor

11. Industry or business _____

12. Name Ben Clay

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

14. Maiden name Mattie Williams

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

16. (a) Informant's own signature Sarah Holmes

(b) Address 825a North Ewing Ave

17. (a) Burial (b) Date thereof 12/27/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director L. H. Randle & Son

(b) Address 3133 Bell Avenue

19. (a) DEC 14 1939 (b) J. J. [Signature]
(Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2841 Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15
year 1939 hour 7:00 minute 20 A. M.

21. I hereby certify that I attended the deceased from December 12, 1939, to December 15, 1939;
that I last saw him alive on December 15, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia, Type 12
Pneumococcus Meningitis
Duration 11 das
3-4das

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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. [Signature] (M. D. or other) _____

Address 2600 N. Whitier Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

12/18/39

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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Howard

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.