

JAN 12 1940

Registration District No. 2001

Primary Registration District No. _____

Registrar's No. 11074

1. PLACE OF DEATH: 1003
 (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 Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME St. John 532
 8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 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: 12-11-39
 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name Berlin St. John
 13. Birthplace Unknown _____
 (City, town, or county) (State or foreign country)
 14. Maiden name Della Vaughn
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Father M. Sherrard
 (b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof DEC 27 1939
 (Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)
 (c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ara Hamilton
 (b) Address City Health Dept.

19. (a) DEC 27 1939 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County 1
 (c) City or town St. Louis 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2709 Washington
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 11
 year 1939 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Unknown (Stillborn) Duration _____
 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 E. Ann Howards _____
 Address 2601 N Whittier 12-23-39
 Date signed

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.

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.