

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.

STANDARD CERTIFICATE OF DEATH

42012

State File No.

Registrar's No.

11135

JAN 12 1940

791

Registration District No.

1000

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St Louis  
 (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 6 days  
 (Specify whether  
 In this community Unknown  
 years, months or days)

3. (a) PRINT FULL NAME Ben Anderson 536

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Unk

6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 1, 1877  
 (Month) (Day) (Year)

8. AGE: Years 62 Months 0 Days 14 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business Unknown

12. Name John Anderson

18. Birthplace Unk  
 (City, town, or county) (State or foreign country)

14. Maiden name Becky Paster

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

16. (a) Informant's own signature Florence S Spotts

(b) Address Homer G Phillips Hospital

17. (a) \_\_\_\_\_ (b) Date thereof 12-20-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. Ricketts  
 (b) Address 3100 Rutger City

19. (a) DEC 28 1939 (b) \_\_\_\_\_  
 (Date received local registrar) (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. 2925 Sheridan  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 15 day 15  
 year 1939 hour 2:00 minute 40 P.M.

21. I hereby certify that I attended the deceased from  
December 9, 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 Pneumococcus Meningitis About 6-7 days

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 \_\_\_\_\_

28. Signature H. J. Lyman (M. D. or other) \_\_\_\_\_  
 Address 2601 N Whittier Date signed 12/16/39

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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.**