

JAN 13 1940  
Registration District No. **1003**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **11166**

1. PLACE OF DEATH: **1**  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution Homer Phillips  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days 335

2. USUAL RESIDENCE OF DECEASED: **1**  
(a) State mo (b) County \_\_\_\_\_  
(c) City or town St. Louis **21**  
(d) Street No. 1921 1/2 Franklin (Rear)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Sidney Staton  
8. (b) If veteran, name war \_\_\_\_\_  
8. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 12 day 17  
year 1939 hour 12 minute 00 P. M.

4. Sex male 5. Color or race Col  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

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.

8. AGE: Years abt 54 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic Myocarditis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Laborer  
11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace "  
14. Maiden name "  
15. Birthplace "

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? \_\_\_\_\_

MOTHER FATHER  
16. (a) Informant's own signature W. Carson - P.D.  
(b) Address 5768 Wren  
17. (a) \_\_\_\_\_ (b) Date thereof 12-19-39  
(c) Place: burial or cremation Wentworth V. Burial  
18. (a) Signature of funeral director W. Carson  
(b) Address 3100 Benton  
19. (a) DEC 29 1939 (b) J. P. Baddock  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place)  
(c) Means of injury 4  
23. Signature Joseph M. Dunsen  
Address Deputy Coroner

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.

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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.**