

3-1-1940
 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.

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Koch
 (c) Name of hospital or institution Robert Koch Hospital
 (d) Length of stay: In hospital or institution 10 mo. 5 days
 In this community Life

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
 (d) Street No. 3117 Hickory
 (e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME ALVIN RICH. 9117
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
 4. Sex Male 5. Color or race Negro
 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 10 9 35
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 30
 year 1940 hour 9 minute 50 A.
 21. I hereby certify that I attended the deceased from 3-25, 1939, to 1-30, 1940
 that I last saw him alive on 1-30, 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years 4 Months 3 Days 21 If less than one day hr. 0 min. 15
 9. Birthplace St. Louis (City, town, or county) (State or foreign country) Mo
 10. Usual occupation none (1)
 11. Industry or business _____ (9)
 12. Name Walter Humphrey (9)
 13. Birthplace _____ (City, town, or county) (State or foreign country) _____ (9)
 14. Maiden name Bernice Rich (City, town, or county) (State or foreign country) no record
 15. Birthplace _____ (City, town, or county) (State or foreign country) _____

Immediate cause of death tuberculosis of vertebral column 4 yrs
 Due tuberculosis of bones & joints 3 yrs
 Due to GB
 Other conditions Secondary anemia 2 yrs
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 16. (a) Informant's own signature H. S. Miller M.D.
 (b) Address Koch Mo.
 17. (a) _____ (b) Date thereof 2-2-1940
 (Burial, cremation, or disposal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Cem
 18. (a) Signature of funeral director Boyd Bros Fun Home
 (b) Address 3704 Finney Ave
 19. (a) JAN 31 1940 (Date received local registrar)
 (b) R. M. Meyer M.D. (Registrar's signature)

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?
 23. Signature Herbert S. Miller (Specify type of place) (e) Means of injury 10'
 Address Koch, Mo. (M. D. number) 1
 Date signed 1-31-40

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.