

FILED MAR 12 1940
791

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis ms
(b) City or town St Louis ms
(c) Name of hospital or institution: 2020 Wash St 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME: CHARLES COTTON

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

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

6. (b) Name of husband or wife Ella 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 7 4 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 7 If less than one day hr. min.

9. Birthplace Mo 14
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant's own signature Allen Cotton

(b) Address 2020 Wash St

17. (a) Burial (b) Date thereof 2 17 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director J. Smith

(b) Address 4247 W Lafayette

19. (a) FEB 16 1940 (b) _____
(Date received local registrar) (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. 2020 WASH ST
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1940 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 6 to Feb 11, 1940
that I last saw him alive on Feb 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 5 d

Due to severe gain caused by

Due to by hyperextension

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

Major findings: Of operations 8 2 d

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 W. G. M. ... (M. D. or other) _____
Address 2325 ... Date signed 2-17

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 Henry Goodin

Licensed Embalmer No. 3050

P. O. Address 4237 W. Habada

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.