

FILED APR 16 1940

Registrar's No. **2173**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town _____
(c) Name of hospital or institution City Hospital 3
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

Ernest Whittaker

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex male 5. Color or race White 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)

8. AGE: Years abt 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Redder

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name _____

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

16. (a) Informant Richard O'Connell - P

(b) Address 63114 Delmonico

17. (a) _____ (b) Date thereof 2-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director James H. [unclear]

(b) Address 1234 [unclear]

19. (a) MAR 4 1940 (Date received local registrar) _____ (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 819 Market
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 18
year 1940 hour 5 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 _____

Primary Occlusion

Due to _____

Due to Cardiac Hypertrophy

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

Duration

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 Joseph M. [unclear] (M.D. or Other) _____

Address Deputy Coroner Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.