

No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17212**

ED JUN 15 1940 791 - 1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **4690**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Hrs. 20 Min.**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **3425 Market**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Malcolm Cowans** **520**

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 _____

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

7. Birth date of deceased **4-26-40**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **5 hr. 20P. min.**

9. Birthplace **St. Louis** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Malcolm Cowan**

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

14. Maiden name **Martha Murray**
15. Birthplace **Oceola, Ark.**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. M. Sherard**

(b) Address **2601 N Whittier**

17. (a) **Burial** (b) Date thereof **5-29-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **Ira Hamilton**

(b) Address **City Health Dept.**

19. (a) **MAY 28 1940** **J. F. Ballack**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **26th**
year **1940** hour **5** minute **20 P. M.**

21. I hereby certify that I attended the deceased from **4-26-** **1940** to **4-26-** **1940**
that I last saw him alive on **4-26-** **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **prematurity**
Atelectasis

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

Major findings: Of operations _____
Of autopsy **Same**

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 **G. E. Place** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.