

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No.

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:
De. Paul
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Days
(Specify whether _____)
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Ferguson
(If outside city or town limits, write "RURAL") N.R.
(d) Street No. 160 Cunningham
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1940 hour 4:15 minute 13 M.
21. I hereby certify that I attended the deceased from June 1st
1940 to July 24 - 1940
that I last saw h. alive on July 24 - 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis Meningitis Duration 2 weeks

Due to _____
Due to 73
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations _____
Of autopsy Melanin tubercles
fungi involved

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) L
(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 Ray Johnson (M. D. or other)
Address Ferguson Mo. Date signed 7-25-40

PHYSICIAN
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME LOUIS WELLS BRIGGS 620

8. (b) If veteran, name war No. 3. (c) Social Security No. None

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. January 24, 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 6 0 hr. min.

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

10. Usual occupation None

11. Industry or business 0

12. Name Everett Briggs

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

14. Maiden name Iola Tayon

15. Birthplace St. Charles Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Everett Briggs

(b) Address 160 Cunningham

17. (a) Burial (b) Date thereof July 26, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles

18. (a) Signature of funeral director Callen Kelly

(b) Address 7267 Natural Bridge

19. (a) JUL 25 1940 (b) J. F. Bredek
(Date entered by Registrar) (Registrar's signature)

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 Clément McNeary

Licensed Embalmer No. 2702

P. O. Address St. Louis

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.