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10-39  
10-39

SEP 25 1940

791

Registration District No.

Primary Registration District No.

1003

State File No.

Registrar's No.

6526

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: H G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
In this community Unknown  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4164 Lexington  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

GEORGE ANDERSON

536

3. (b) If veteran, name war \_\_\_\_\_

Unk

3. (c) Social Security No. Unk

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Unk

6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10  
year 1940 hour 7:20 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from July 6, 1940, to July 10, 1940; that I last saw him alive on July 10, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease Duration 15 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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 Allen (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed \_\_\_\_\_

8. AGE: Years About 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unk

11. Industry or business Unk

12. Name Unk 9

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

14. Maiden name Unk 9

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

16. (a) Informant Florence A Spatta

(b) Address 2601 N Whittier

17. (a) \_\_\_\_\_ (b) Date of report 7-13-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director W. R. R. R.

(b) Address 3500 R. R.

19. (a) AUG 2 1940 (b) J. G. R. R.  
(Date received local registrar) (Registrar's signature)

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

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**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 complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**