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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29625
Registrar's No. 1609

Registration District No. 784

Primary Registration District No. 202

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 676 days
(Specify whether)

In this community 432
years, months or days

8. (a) PRINT FULL NAME Sledge, Richard

8. (b) If veteran, name war No

3. (c) Social Security No. 335-105-001

4. Sex M

5. Color or race Negro

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

6. (b) Name of husband or wife Mary Sledge

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

7. Birth date of deceased December 21, 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>7</u>	<u>28</u>	hr. min.

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

10. Usual occupation Steel foundry worker

11. Industry or business Steel foundry

MOTHER FATHER

12. Name Richard Sledge

18. Birthplace Alabama
(City, town, or county) (State or foreign country)

14. Maiden name Lillian Williams

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

16. (a) Informant Patent

(b) Address 1620 Caber

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Aug. 24, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Co.

18. (a) Signature of funeral director F. A. Green

(b) Address 2415 Franklin

19. (a) AUG 24 1940 (Date received local registrar)

(b) R. W. Polk (Registrar's signature)

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. 1620 Carr St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1940 hour 9 minute 10 P. M.

21. I hereby certify that I attended the deceased from Oct. 8
1938, to Aug 19, 1940,
that I last saw him alive on Aug 19, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis

Duration 3 1/2 yrs

Due to _____

Due to IBP

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

PHYSICIAN

Major findings: Left tuberculous emphysema

Of operations _____

Of autopsy None

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 R. W. Polk (M. D. ~~certified~~)

Address Koch Mo Date signed 8/19/40

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed

J. A. Green

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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.