N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30096

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 7373

OCT 25 1940

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 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mos 18 days (Specify whether years, months or days)

In this community 23 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL") 23

(d) Street No. 1545 S 2nd (If rural, give location)

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

3. (a) PRINT FULL NAME Julia Whiteside

3. (b) If veteran, name war ********

3. (c) Social Security No. Unk

4. Sex FEMALE M

5. Color or race Negro

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

6. (b) Name of husband or wife Unk Unk

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

7. Birth date of deceased August 15, 1848 (Month) (Day) (Year)

8. AGE: Years 91 Months 11 Days 28 If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business Nil

FATHER 12. Name Cass Walker

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

MOTHER 14. Maiden name

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

16. (a) Informant's own signature Florence A. Spotts

(b) Address 2601 N Whittier

17. (a) (Burial, cremation, or removal) (b) Date thereof 8-22-40 (Month) (Day) (Year)

(c) Place: burial or cremation Washington C

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

(b) Address 3800 Lutz

19. (a) SEP 3 1940 (Date received local registrar) (b) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13 year 1940 hour 11:55 minute a.m.

21. I hereby certify that I attended the deceased from March 25, 1940, to August 13, 1940; that I last saw her alive on August 13, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	1 wk
Senility	Indef
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. W. Johnson (M. D. or other)

Address 2601 N Whittier Date signed 8/19/40

(Licensed Embalmer's Statement on Reverse Side)

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 wi the above constitutes grounds for revocation of license.)

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