

No. 2
12-40
17-39
X23

FILED OCT 10 1940 784

Registration District No. _____

Primary Registration District No. 111

Registrar's No. 1864

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8102 Dale Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

In this community 3 weeks
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")

(d) Street No. 8102 Dale Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME John Phinnessee

3. (b) If veteran, name war Hil

3. (c) Social Security No. Hil

4. Sex Male 5. Color or race Col

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

6. (b) Name of husband or wife Francis Phinnessee

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

7. Birth date of deceased Sept 8 1889
(Month) (Day) (Year)

8. AGE: Years 51 Months 0 Days 24

If less than one day hr. _____ min. _____

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Briscoe Phinnessee

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

14. Maiden name Sarah Chestee

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

16. (a) Informant Res. L. G. Phinnessee

(b) Address 1947 Tudor Ave

17. (a) Removal (b) Date thereof 10-4-40
(City or town) (County) (State) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethel Cem.

18. (a) Signature of funeral director [Signature]

(b) Address 3517 S. Alledo Ave

19. (a) OCT - 3 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2
year 1940 hour 12 minute 43 P.M.

21. I hereby certify that I attended the deceased from 9-15-40
19____ to 10-2 1940

that I last saw h. alive on 9-20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Duration 1 year

Due to 93.0

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 [Signature] (M. D. or other) _____

Address 1341 Riggall Ave Date signed 10/13/40

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

A. M. Green

Licensed Embalmer No. *1173*

P. O. Address

3517 Soledad

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, fact should be so stated above.