

16 1940
Registration District No. 791

Primary Registration District 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: Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26 days
(Specify whether
In this community 35 years
years, months or days)

8. (a) PRINT FULL NAME Tom Nick

8. (b) If veteran, name war Unk 8. (c) Social Security No. Unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 1, 1885
(Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 25 If less than one day hr. _____ min.

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

10. Usual occupation Unk

11. Industry or business _____

MOTHER { 12. Name Dennis Nick

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

14. Maiden name Mollie

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

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

(b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 9-11-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

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

(b) Address 3500 Risher

19. (a) OCT 1 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 305 N Third
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26
year 1940 hour 1:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Ulcer of Lt Leg

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 Edell W. Butts (M. D. or other)
Address 2601 N Whittier Date signed _____

Duration

3-4 yrs
6 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.

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 with the above constitutes grounds for revocation of license.)

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