

S. No. 2
-11-10-39
-5-17
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33528**

Registrar's No. **8225**

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

NOV 16 1940 791

Registration District No. _____ Primary Registration District No. **1003**

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:
4416 St. Ferdinand Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4416 St. Ferdinand Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Robert Clay

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 1st 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 5 hr. 10 min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Fredrick B. Clay

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

14. Maiden name Mendell Gray

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

16. (a) Informant Fredrick B. Clay

(b) Address 4416 St. Ferdinand Ave.

17. (a) Burial (b) Date thereof 10/2/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 4107 Finney Ave.

19. (a) OCT 2 1940 (Date received local registrar) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1st.
year 1940 hour 11:45 minute a. m.

21. I hereby certify that I attended the deceased from 10-1- 1940 to 10-1- 1940
that I last saw him alive on 10-1- 1940
and that death occurred on the day and hour stated above.

Immediate cause of death Pneumonia Duration _____

Burial (7 months)

Due to _____

Due to _____

Other conditions remains

(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 L. H. Vincent (M. D. or other) _____
Address 2336a Market St. Date signed 10/1/40

STATEMENT BY LICENSED EMBALMER

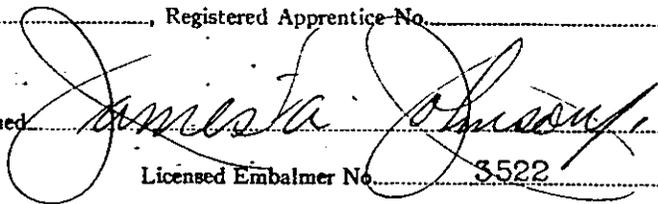
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No.

working under my personal supervision.

Signed



.....
Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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.