

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.

Registration District No. 791

Primary Registration District No.

1. CAUSE OF DEATH:

(a) County St Louis
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer & Phelps Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME HATTIE BRIGGS
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Cal
 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 Jan 29 1902
 (Month) (Day) (Year)

8. AGE: Years 38 Months 8 Days 14
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Maids

11. Industry or business House Work

MOTHER FATHER
 12. Name J R Moore
 13. Birthplace Not known Miss
 (City, town, or county) (State or foreign country)
 14. Maiden name Maguire Mc Gee
 15. Birthplace Baldwin Miss
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
 (b) Address 29 21 Coarbin

17. (a) Burial (b) Date thereof 10-19-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director A D Richardson
 (b) Address 26 25 Glasgow

19. (a) Oct 18 1940 (b) J F Bender
 (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 21
 (If outside city or town limits, write "RURAL")
 (d) Street No. 29 21 Coarbin
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12th
 year 1940 hour 11 minute 15 P M.
 21. I hereby certify that I attended the deceased from Oct 5th
1940 to Oct 12th, 1940;
 that I last saw her alive on Oct 12th, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart disease and acute hepatitis with uremia
 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 M L McGinnis (M. D. or other)
 Address 826 N. Beaumont Date signed 10/13/40

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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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. D. Richardson*

Licensed Embalmer No. *2928*

P. O. Address *2625 Dallas*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33904
Registrar's No. 8661

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homeer Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Hattie Briggs
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced, or separated
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased: (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 11-25-40 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

20. DATE OF DEATH: Month Oct. Day 12 Year 1940
hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular heart disease
Due to acute nephritis & uremia

Due to cause undetermined

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

Major findings: Of operations 92h

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?
(Specify type of place) (e) Means of injury

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other).....
Address Date signed

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

