

BUREAU OF THE CENSUS
FILED JAN 15 1940

7912
STANDARD CERTIFICATE OF DEATH
1003

State File No. 40417

Registrar's No. 10188

Registration District No. _____

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution about 19 hrs
(Specify whether
 In this community 18yrs
years, months or days)

8. (a) PRINT FULL NAME Mildred Stevens

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

4. Sex Female 6. Color or race C 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Sept 3rd 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>3</u>	<u>5</u>	hr. _____ min. <u>0</u>

9. Birthplace West Plains Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Henry Farrar

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

14. Maiden name Diana Campbell

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

16. (a) Informant Charles C Stevens

(b) Address 2164 Farrar Street

17. (a) removal (b) Date thereof 12-13-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains Mo

18. (a) Signature of funeral director J. H. Randle & Son

(b) Address 3133 Bell Avenue

19. (a) DEC 11 1940 (b) J. W. Budnik
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
 (d) Street No. 2164 Farrar Street
(If rural, give location)
 (e) No Attending Physician
(If not in U.S., give location) _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8th
 year 1940 hour 2:23 minute P. 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 _____

Carcinoma Inguinal Region

Due to Bilateral

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death) 53

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) (Means of injury) 5

23. Signature Joseph M. Johnson (M.D. or other) _____

Address Deputy Registrar Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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. J. Watson

Licensed Embalmer No. 2498

P. O. Address 2769 Chouteau

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.