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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **5678**  
Registrar's No. **1926**

**FILED MAR 25 1941 791**  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

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: Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 19 days  
In this community 11 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Joe Cade  
(b) If veteran, name war Unk  
3. (c) Social Security No. Unk

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced W  
(b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 14, 1886  
(Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days 19  
If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Rubin Cade

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

14. Maiden name \_\_\_\_\_

15. Birthplace Carrie Hollins Miss  
(City, town, or county) (State or foreign country)

16. (a) Informant Florence A Spotts Clerk

(b) Address Phillips Hospital

17. (a) \_\_\_\_\_ (b) Date thereof 2-5-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

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

(b) Address FEB 28 1941

19. (a) \_\_\_\_\_ (b) J. B. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **0011**  
(a) State Missouri (b) County 17  
(c) City or town St Louis **9 18**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 511 S Ewing  
(If rural, give location) **0**  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 3  
year 1941 hour 12:00 minute Noon M.

21. I hereby certify that I attended the deceased from January 15, 1941, to February 3, 1941,  
that I last saw him alive on February 3, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis **18 mos**  
Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
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 C. Allen (M. D. or other)  
Address 2601 N Whittier Date signed 2/5/41

**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, fact should be so stated above.**