

NO. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23128**
5480

Registration District No. **91**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community 20 yrs. 0 (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 1113 1/2 N Vandeventer
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1941 hour 12:00 minute _____ M.

21. I hereby certify that I attended the deceased from
June 18 1941 to June 30 1941
that I last saw him alive on June 30 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Sclerosis Indef
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 sta-
tistically.

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 [Signature] (M. D. or other) 0
Address 2601 N. Whittier Date signed 7/1/41

3. (a) PRINT FULL NAME General Bryant

3. (b) If veteran, name war ---- 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Mattie Bryant 6. (c) Age of husband or wife if alive ---- years

7. Birth date of deceased November -- 1884
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days -- If less than one day hr. _____ min. _____

9. Birthplace Cusie Co. Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business ----

12. Name Unavailable

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

14. Maiden name Unavailable

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

16. (a) Informant [Signature]

(b) Address 4152 West Belle Pl.

17. (a) Burial (b) Date thereof 7/5/41
(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) JUL 2 1941 (b) [Signature]
(Date received by Registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

0
7
9

87 D

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..... *James A. Johnson*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22128
Registrar's No. 5480

Registration District No. _____ Primary Registration District No. _____

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: Homer 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 General Baryant
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced w
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 57 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 _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) SEP 3 1941 (b) J. F. Prebeck
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 - 41
year _____ hour _____ minute _____ 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 _____ Duration _____

Cerebral sclerosis
cerebral arteriosclerosis

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. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-23128