

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

FILED AUG 28 1941

Registration District No. **7-91** 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:
Homer G. Phillips Hosp.
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution **15 Hrs. & 36 Min.**
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME **Walter Louis Rice**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 2 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **0**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **7 1 41**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **15 hr. 36 min.**

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Willie Rice**
13. Birthplace _____ **Miss.**
(City, town, or county) (State or foreign country)
14. Maiden name **Tarlease Hughes**
15. Birthplace _____ **Ark.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Father May Sherard**
(b) Address **2601 N. Whittier**

17. (a) **burial** (b) Date thereof **7-30-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **Wm Hamilton**
(b) Address **City Health Dept**

19. (a) **JUL 30 1941** (b) **T. T. Bredich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **229**
(d) Street No. **424a So. Jefferson**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1**
year **1941** hour **6** minute **50 PM.**

21. I hereby certify that I attended the deceased from **7-1-1941** to **7-1-1941**
that I last saw him alive on **7-1-1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity** Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **As above**

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? _____

(Specify type of place) _____
While at work _____ (e) Means of injury _____
23. Signature **Lewis J. Hodder** (M. D. or other) _____
Address **H. G. Phillips** Date signed _____

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.....

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.