

FILED NOV 23 1942

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35994

State File No.

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. **9408**

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis, Missouri**
(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 **1 mo. 17 days**
(Specify whether
In this community **25 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis,** (If outside city or town limits, write "RURAL") **17**
(d) Street No. **4209 West Belle** (If rural, give location) **9 11**
(e) Citizen of foreign country? (Yes or No)
If yes, name country. **D**

3. (a) PRINT FULL NAME **Charles Tolar**

3. (b) If veteran, name war **WW** 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color of race **Wh.** 6. (a) Single, widowed, married, divorced **Divorced**

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

7. Birth date of deceased..... **Oct. 16 1901**
(Month) (Day) (Year)

8. AGE: Years **41** Months **-** Days **21** If less than one day..... hr. min.

9. Birthplace **Little Rock Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cook**

11. Industry or business **Hotel**

MOTHER FATHER

12. Name **unknown**

13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Cordelia Green**

(b) Address **4209 West Belle**

17. (a) **Burial** (b) Date thereof **11-12-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **O. W. H. Green**

(b) Address **2829 Washington**

19. (a) **10 1942** (b) **J. P. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **7,**
year **1942** hour **11** minute **55 P. M.**

21. I hereby certify that I attended the deceased from **Sept. 26,** 1942, to **November 7,** 1942;
that I last saw him alive on **November 7,** 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death **Ca. of Rectum and Buttocks**

Due to **Primary in Rectum**

Due to **H/O**

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

Major findings:
Of operations.....

Of autopsy.....

Duration

Unknown

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 **C. K. Fleet** (M. D. or other)

Address **2601 Whittier** Date signed **11/10/42**

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 Oliver Stendell Holmes

Licensed Embalmer No. 4190

P. O. Address 2829 Washington

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.