

Registration District No. **318**

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 Philip Hos**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 hrs** (Specify whether years, months or days) **18 month** **MAN**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **17 (25)**
(c) City or town **St Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **1425 N 13 St** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **BETTY JEAN BUCHANAN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **19**
year **1943** hour **1** minute **25** A.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.

4. Sex **Female** 5. Color or race **3 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 **July 27 41**
(Month) (Day) (Year)

Immediate cause of death **Tuber Pneumonia**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
1 5 25 hr. _____ min.

9. Birthplace **St Louis Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **None**
11. Industry or business _____
12. Name **Sam Buchanan**
13. Birthplace **unknown Miss**
(City, town, or county) (State or foreign country)
14. Maiden name **Annie Mae Chapman**
15. Birthplace **Quintown Miss**
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant _____
(b) Address **1425 N 13 St**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11 22/43**
(Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park**
18. (a) Signature of funeral director **Metrol Station**
(b) Address **3028**
19. (a) **JAN 21 1943** (Date received local registrar) **J. F. Bredek** (Registrar's signature)

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 **Thomas F. Callahan** (Date or other) _____
Address **Deputy Coroner** Date signed **1-20-43**

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

MOTHER FATHER

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 Arthur L. Hilliard

Licensed Embalmer No. 4321

P. O. Address 4219th E. Gayfield 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.