

S. No. 2
FORM-2-43
5-17-39
I X35697

19365

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 8 1940

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5910

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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mos. 17 days
(Specify whether years, months or days)

In this community 21 years
(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. 3141a Franklin
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jake Ambus

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife _____

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

7. Birth date of deceased January 5, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

56	4	25	hr. _____ min.
----	---	----	----------------

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

10. Usual occupation Nil

11. Industry or business _____

12. Name Willis Ambus

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

14. Maiden name Hanna Watkins

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

16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier

17. (a) Autosomal (b) Date thereof 6-2-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

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

(b) Address 3500 ...

19. (a) JUN 28 1940 (b) J. J. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30,
year 1943 hour _____ minute 55 A. M.

21. I hereby certify that I attended the deceased from January 13, 1943 to May 30, 1943,
that I last saw him alive on May 30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions 13
(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 Alvin ... (b) D. or other _____
Address 2601 Whittier Date signed 6/2/43

Duration Unk.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.