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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

JUL 24 1943

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 6473

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 7 days  
In this community 31 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 19  
(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 7 18  
(d) Street No. 3120 LaSalle (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Frank May

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race 0. 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased 10 6 1905  
(Month) (Day) (Year)

8. AGE: Years 37 Months 9 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Seaman

11. Industry or business \_\_\_\_\_

12. Name Idea May

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

14. Maiden name Mathe May

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

16. (a) Informant Harriet Bruce

(b) Address 3120 La Salle

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 7/19/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director English & Co.

(b) Address 2931 Levee

19. (a) JUL 18 1943 (Date received local registrar) (b) J. F. Bruce (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15, year 1943 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from July 8, 1943 to July 15, 1943 that I last saw him alive on July 15, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

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 Alvin Moore (M. D. or other)

Address 2601 Whittier Date signed 7/16/43

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

MOTHER FATHER

Duration

Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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: *Burleson English*

Licensed Embalmer No. *4208*

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.**