

X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36357

FILED NOV 20 1943

Registration District No. _____

Primary Registration District No. _____

1003

State File No. _____

Registrar's No. _____

10043

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 9 days (Specify whether Life)
In this community _____
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. 1900a Division (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Preston Foster

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race Colored

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

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

7. Birth date of deceased October 3, 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 days hr. min.

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

10. Usual occupation _____

11. Industry or business nil

MOTHER FATHER { 12. Name Madison Banks
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Chapman
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith
(b) Address 2601 N. Whittier St.

17. (a) Burial (b) Date thereof NOV 18 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director H. Merschman

(b) Address City Health Dept

19. (a) NOV 17 1943 (b) J. F. Bredlak
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29,
year 1943 hour 11 minute 40 A. M.

21. I hereby certify that I attended the deceased from October 20, 1943, to October 29, 1943
that I last saw him alive on October 29, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis (Autopsy) Duration 9 days

Due to Appendix, Strangulated with Gangrene (Autopsy)

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (a) Means of injury _____

23. Signature A. M. Jackson (M. D. or other) _____
Address 2601 N. Whittier Date signed 11/17/43

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.

Registration District No. 318 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: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME

Preston Foster

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race C 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JAN 15 1944 (b) J. F. Budeck (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1943 Minute _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 5 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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

36357