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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5132

FILED FEB 28 1944

Registration District No. ____ Primary Registration District No. 1002 Registrar's No. 1424

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

(d) Length of stay: In hospital or institution 10 Days (Specify whether years, months or days)

In this community ____

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. 2640 Lucas Ave.
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME Frank William Garrett Jr.

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 ____

6. (b) Name of husband or wife ____

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

7. Birth date of deceased 1 (Month) 29 (Day) 44 (Year)

8. AGE: Years ____ Months ____ Days 10 If less than one day ____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name Frank William Garrett Sr.
13. Birthplace Nashville (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name Elizabeth Vaughn
15. Birthplace Nashville (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant Esther M. Sherard, R.N.
(b) Address 2601 N. Whittier Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-44 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director McDowell
(b) Address 1711 N. Taylor Ave.

19. (a) FEB 14 1944 (Date received local registrar) (b) J. F. Bruecken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 8 year 44 hour 11 minute P.M.

21. I hereby certify that I attended the deceased from 1-29- 19 44 to 2-9- 19 44 that I last saw him alive on 2-9- 19 44 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity — Duration

Due to Unknown

Due to Unknown

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)

While at work? ____ (e) Means of injury ____

23. Signature L. B. Bourne (M. D. or other)

Address 2601 N. Whittier St. Date signed 2-11-44

(Licensed Embalmer's Statement on Reverse Side)

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 .....

not embalmed ....., Registered Apprentice No. .....,

working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

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.