S. No. 2
0M—2-43
5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 20 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13359

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 3274

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: Mo. Baptist Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5219 Ashland Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Timmie Lee Small
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
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 Mar (Month) 25 (Day) 1944 (Year)
8. AGE: Years | Months | Days 12 | If less than one day hr. min.
9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name James D. Small
13. FATHER Birthplace Ky (City, town, or county) (State or foreign country)
14. MOTHER Maiden name Dorthy Drummond
15. MOTHER Birthplace Mo (City, town, or county) (State or foreign country)
16. (a) Informant James D. Small
(b) Address 5219 Ashland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Ap 8-44 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Pk Cem
18. (a) Signature of funeral director Drehmann-Hazel
(b) Address 1905 Union Blvd.
19. (a) APR 8 1944 (Date received by local registrar) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 7 year 1944 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from 3/27, 1944 to 4/7, 1944 that I last saw him alive on 4/6/44, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Infected Spina Bifida — Duration 12 days
Due to Lack of development
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)
While at work? (e) Means of injury
23. Signature N. O. Thompson (M. D. or other) M.D.
Address 4439 San Francisco Date signed 4/8/44

(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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

No Embalming

Signed Warren A. Carver

Licensed Embalmer No. 3534

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.