

V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32351**

FILED NOV 1 1944
318

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **9083**

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

1. PLACE OF DEATH:

(a) County St. Louis

(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 of location)

(d) Length of stay: In hospital or institution 26 1/2 Hrs.
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Cecil Hale 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,** 0 divorced

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

7. Birth date of deceased 9 8 44
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>1</u>	<u>25</u> hr. <u>30</u> min.

9. Birthplace St. Louis 0 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { **12. Name** Cecil Hale Sr.

{ **13. Birthplace** Little Rock / Arkansas
(City, town, or county) (State or foreign country)

{ **14. Maiden name** Alean Cunningham

{ **15. Birthplace** Little Rock / Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Duwall

(b) Address 2601 N. Whittier St.

17. (a) Burial **(b) Date thereof** OCT 26 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. B. Hudson

(b) Address City Health Dept

19. (a) OCT 26 1944 **(b)** J. B. Hudson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 755 Aubert St.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 9
year 44 hour 4 minute 00 p.M.

21. I hereby certify that I attended the deceased from 9 - 8
_____ 19 44 9 - 9, 19 44
9 - 9, 19 44
that I last saw him alive on _____
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 157
(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. B. Sinkler (M. D. or other) _____

Address 2601 N. Whittier St. **Date signed** _____

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.