V. S. No. 2
100M—5-43
Rev. 5-17-39
No. I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 132

FILED JAN 31 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 75

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 9 Days (Specify whether years, months or days)

In this community 0

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. 2928 Delmar
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Ronald Leandra Cason

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 12 (Month) 8 (Day) 44 (Year)

8. AGE: Years | Months | Days 9 | 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 John W. Cason
13. Birthplace Nashville (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name Hattie Pearl Harris
15. Birthplace Nashville (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant Mary T. Duvall
(b) Address 2601 N. Whittier Street

17. (a) (Burial, cremation, or removal) (b) Date thereof JAN 25 19 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept

19. (a) JAN 24 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 17 year 44 hour 11 minute 00 P.M.

21. I hereby certify that I attended the deceased from 12 - 8, 1944, to 12 - 17, 1944 that I last saw him alive on 12 - 17, 1944 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 William N. Sutter (M. D. or other)

Address 2601 N. Whittier St. Date signed 1-20-45

(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.

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.