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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22612

State File No.

6778

Registrar's No.

FILED AUG 11 1945
Registration District No. 318

Primary Registration District No. 100

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 8 days
In this community 4 years
(Specify whether years, months or days)

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. 717 W. Compton
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Stephenson

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

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased May 29 1971
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 0 If less than one day — hr. — min.

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

10. Usual occupation labor

11. Industry or business

12. Name Walter Stephenson

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

14. Maiden name Frances Jones

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

16. (a) Informant Nellie Jaeger

(b) Address 717 W Compton

17. (a) Burial (b) Date thereof Aug 1 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director English and Co.

(b) Address 2931 Press

19. (a) AUG 1 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29, year 1945 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from July 21, 1945 to July 29, 1945; that I last saw h. im alive on July 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach Duration Unk.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(c) 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 P. F. Murphy (M. or other)

Address 2601 White Date signed 7/31/45

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

MOTHER FATHER

204

(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..... *Burleson - English*
Licensed Embalmer No..... *4208*
P. O. Address..... *2931 Lucas Ave*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318Primary Registration District No. 1003Registrar's No. 6778

AUG 13 1945

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

years, months or days)3. (a) PRINT
FULL NAMEJames Stephenson

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex
- m
-
5. Color or
-
- race
- B

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

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

7. Birth date of deceased
- May 29
-
- (Month) (Day) (Year)

8. AGE: Years
- 74
- Months Days
- hr. min.
-
- If less than one day

9. Birthplace
- Tenn
-
- (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)
- (Burial, cremation, or removal)
- (b) Date thereof.....
- (Month) (Day) (Year)

- (c) Place: burial or cremation.....

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

- (b) Address.....

19. (a)
- AUG 20 1945
- J. J. Brudeck
-
- (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
- July
- Day
- 29
-
- Year
- 1945
- Hour
- 10
- minute
- 29
- M.

21. I hereby certify that I attended the deceased from
-
- to
-
- that I last saw him..... alive on..... 19.....
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death.....

Duration

- Due to.....

- 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 sta-
tistically.

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.....

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

SUPPLEMENTARY

FILE

S-22612