

S. No. 2
M-5-43
v. 5-17-39
I X36671

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

State File No. _____
Registrar's No. **7957**

FILED SEP 24 1946
318

Registration District No. _____ Primary Registration District No. **1003**

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

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

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. **3124 LA SALLE, St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME **MILTON CLAY**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **11** ^{ca}
year **1946** hour **2** minute **00** **AM**
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex **Male** 2 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death _____
Cerebral Apoplexy
Due to _____
Due to _____

7. Birth date of deceased **AUG 2 1886**
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
60 1 9 hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace **UNK.** **MO.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Laborer**

MOTHER FATHER
11. Industry or business _____
12. Name **HENRY CLAY**
13. Birthplace **UNK** **MO**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY** ?
15. Birthplace **UNK** **MO**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **EARL CLAY**
(b) Address **3124 LASALLE**
17. (a) **Burial** (b) Date thereof **Sept 16, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peters**

While at work? _____ (Specify type of place) _____
Means of injury _____
23. Signature **[Signature]** (M. D. or other) _____
Address _____ Date signed **9/16/46**

18. (a) Signature of funeral director **English Und. Co**
(b) Address **2931 LUCAS, AVE**
19. (a) **SEP 16 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

(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

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.