

S. No. 2
-12-45
5-17-39
71 X47070

FILED OCT 31 1946
Registration District No. 318

Primary Registration District No. 1003

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 1 1/2 Mos
In this community 17 Years
years, months or days (Specify whether)

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. 2723 Stoddard
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Peter Daniels
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 26
year 1946 hour 8 minute 50 P M.

4. Sex Male 5. Color or race Col
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Carrie Daniels
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased September 27th 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-18 1946 to 9-26 1946
that I last saw him alive on Sept. 26 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
80 II 29
hr. min.

Immediate cause of death.....
Uremia with Arteriosclerotic Kidney Hypostatic Pneumonia
Duration Undet.

9. Birthplace Atlanta Georgia
(City, town, or county) (State or foreign country)

Due to.....
Due to.....
Other conditions None
(Include pregnancy within 3 months of death)

10. Usual occupation Laborer

11. Industry or business.....

Major findings:
Of operations.....
Of autopsy No
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Peter Daniels
13. Birthplace Georgia
(City, town, or county) (State or foreign country)
14. Maiden name Un Known
15. Birthplace Georgia
(City, town, or county) (State or foreign country)

16. (a) Informant Georgia Lee Johnson
(b) Address 3429 Rear Franklin Ave.

17. (a) Burial (b) Date thereof 10/1/1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery.

18. (a) Signature of funeral director J. F. Bredeek
(b) Address 2834 Gamble Street

19. (a) SEP 30 1946 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

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) Means of injury.....
23. Signature D. W. Brown (M. D. or other)
Address 2601 N. White Date signed 9/29/46

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

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

Char. L. Howell

Licensed Embalmer No.

2452

P. O. Address

2834 Hamble

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.