

No. 2
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17-39
K33569

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32268

FILED SEP 30 1946
318

State File No. _____
Registrar's No. **8201**

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:
4435 Maffitt Avenue
(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 **Missouri** (b) County **18000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4435 Maffitt Avenue** **9**
(If rural, give location) **0**
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Sydnor**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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
7. Birth date of deceased **1 15 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 8 5 hr. min.

9. Birthplace **Troy, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business **nil**

MOTHER FATHER
12. Name **Louis Sydnor**
13. Birthplace **Troy, Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Arlice Green**
15. Birthplace **Troy, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rachel Taylor**
(b) Address **4435 Maffitt Avenue**

17. (a) **Removal** (b) Date thereof **9/24/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Troy, Missouri**

18. (a) Signature of funeral director **Russell Und., Co.**
(b) Address **2732 Pine Street**

19. (a) **SEP 24 1946** (b) **J. F. Bruders**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH Month **9** day **20**
year **1946** hour **6** minutes **0** M.
21. I hereby certify that I attended the deceased from _____
that I last saw him alive on **9/18/46** 19____
and that death occurred on the date and hour stated above. 19____

Immediate cause of death **Cerebral apoplexy**
Duration **4 days**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **80**

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) **None**
(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 **J. F. Bruders** (M. D. or other) _____
Address **4322 1/2 E. 8th St.** Date signed **9/23**

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 Clark Young

Licensed Embalmer No. 33712

P. O. Address St. Louis

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.

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:

(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)

3. (a) PRINT FULL NAME William Sydney

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Year 76 Months 8 Days 5 (Unless than one day) hr. min.

9. Birthplace..... (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) (Date received local registrar) (b) J. J. [Signature] (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 February Year 1947 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from..... to....., 19...; 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 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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

32268

5