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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3197

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **233**

1. PLACE OF DEATH:

(a) County St. Louis
(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)

3. (a) PRINT FULL NAME Eugene Temple
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 Mattie Temple
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Sept. 11, 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 3 24 5 hr. min.

9. Birthplace Russellville, Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Grocery store

12. Name Robert Temple

13. Birthplace ? Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Kate Owens

15. Birthplace ? Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Temple
(b) Address 3129 School

17. (a) Burial (b) Date thereof 1/10/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Russell Und., Co.
(b) Address 18732 Pine Street

19. (a) JAN 9 1947 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

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. 4243 Easton Ave
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5
year 1947 hour 5 minute XX P.M.

21. I hereby certify that I attended the deceased from 11-27-, 19 46, to 1-5, 19 47,
that I last saw him alive on Jan. 5, 19 47,
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 10 days

Due to 107

Due to

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

Major findings:
Of operations.....

Of autopsy Yes

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 E. B. Williams (M. D. or other).....

Address 2601 N Whittier St. Date signed 1/16/47

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

Clark Y. Young

Licensed Embalmer No.....

3371

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.