FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 9 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14802

Primary Registration District No. 1003

Registrar's No. 4360

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: 19 days (Specify whether years, months or days)

In this community: 8 years

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.: 20 So 21st St
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Phillip Alexander

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: Col

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: Unknown

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Mar. (Month) 15 (Day) 1866 (Year)

8. AGE: Years 81 | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace: Drain Bay (City, town, or county) Miss (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

MOTHER FATHER

12. Name: HORACE ALEXANDER

13. Birthplace: (City, town, or county) Miss (State or foreign country)

14. Maiden name: not Known

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

16. (a) Informant: BEVELL ALEXANDER

(b) Address: 3419 Lucas Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4 30 47 (Month) (Day) (Year)

(c) Place: burial or cremation: OAK DALE

18. (a) Signature of funeral director: HOWELL FUNERAL

(b) Address: 2834 Gamble St.

19. (a) APR 29 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1947 hour 1 minute A M.

21. I hereby certify that I attended the deceased from 4-7, 1947 to 4-26, 1947 that I last saw him alive on April 26, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
General Paresis; Uremia (3 days)	Undet.
Due to	
Due to	
Other conditions: Neurogenic Bladder (Include pregnancy within 3 months of death)	

Major findings:
Of operations:

Of autopsy: No

PHYSICIAN — Underline the cause of 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: 0

23. Signature: Daniel W. Brown (M. D. or other)

Address: 2601 N Whittier Date signed: 4/28/47

Jefferson City Printing Co.

(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 Chas. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit 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 CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14802

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 4360

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)

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 .....

3. (a) PRINT FULL NAME Philip Alexander

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

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

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

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

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) 4-19-48 (Date received local registrar) (b) J. F. Bredest (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1948 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h..... alive on ....., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

General Paresis,

Due to .....

Syphilitic

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?
..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

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