No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 21 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29093

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7725

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Infirmary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11/26/36 (Specify whether years, months or days) In this community to 8/13/47

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0-7-0
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal St 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles Hainsworth
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male 1
5. Color or race Colored
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Year 1866 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
abt - 81	?	?	hr. min.

9. Birthplace Meridian, Mississippi 1
(City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name Gabngen Hainsworth
13. Birthplace Unavailable, S. Carolina 1
(City, town, or county) (State or foreign country)
14. Maiden name Ruth Parker
15. Birthplace Unavailable, S. Carolina 1
(City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal ST
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Avenue
19. (a) AUG 19 1947 (Date filed with Registrar) (b) J. F. Broderick (Registrar's signature)

Jefferson City Printing Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug., day 13 year 1947 hour 1 minute A M.
21. I hereby certify that I attended the deceased from 11/26, 19 36 to 8/13, 19 47 that I last saw him alive on 8/13, 19 47 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Cerebral hemorrhage
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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

23. Signature Warren C. Lewis M. D.
Address 5600 Arsenal Date signed 8-13-47

(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

Thomas J. Gates Registered Apprentice No.

working under my personal supervision.

Signed Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.