

No. 2  
1/47  
17-39

FILED NOV 3 1947  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9710**

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:  
Honer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 3 days  
(Specify whether

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME..... Frank Bost

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex..... Male Color or race..... Cal

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

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

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

7. Birth date of deceased..... April 14 1917  
(Month) (Day) (Year)

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

30 6 3 hr. min.

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

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... Fowler Bost

13. Birthplace..... Jefferson County Ark  
(City, town, or county) (State or foreign country)

14. Maiden name..... Lena Seaton

15. Birthplace..... Jefferson County Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant..... Lee Bost

(b) Address..... 2038 O'Fallon

17. (a) Date of death..... 10-20-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Clarendon Ark

18. (a) Signature of funeral director..... J. P. Richardson

(b) Address..... 2038 O'Fallon

19. (a) Date received local registrar..... OCT 26 1947

(b) Signature of Registrar..... J. P. Bost  
(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. 21 2038 O' Fallon  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

20. DATE OF DEATH: Month..... Oct. day..... 17  
year..... 1947 hour..... 11 minute..... A M.

21. I hereby certify that I attended the deceased from..... Oct. 14 to..... Oct. 17 19..... 47  
that I last saw him..... alive on..... Oct. 17 19..... 47  
and that death occurred on the date and hour stated above.

Duration.....

Immediate cause of death.....  
Infectious Hepatitis  
Obstructive Uropathy

Undet.

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy..... None

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?..... (Specify type of place)

23. Signature..... Charles J. Daniels  
Address..... 2601 N Whittier Date signed..... 10/18/47

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

MOTHER FATHER

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 *Richardson*  
Licensed Embalmer No. *2928*  
P. O. Address *City*

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. 314

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 Frank Bond

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

4. Sex m 5. Color of race B 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 April 14 (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 \_\_\_\_\_

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. F. Brennan (Registrar's signature) NOV 5 1947

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 \_\_\_\_\_ Year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-35528

Dr. 8/5/52