

S. No. 300
M-10-47
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14699**
Registrar's No. **3421**

FILED APR 23 1948 318
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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **27 days**
In this community **40 yrs.**
years, months or days (Specify whether)

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

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Rosie Sykes**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 24 1889**
(Month) (Day) (Year)

8. AGE: Years **58** Months **3** Days **12**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Labor**

11. Industry or business _____

MOTHER FATHER { 12. Name **Henry Sykes**
13. Birthplace **Miss**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

15. (a) Informant **John H. Sykes**
(b) Address **Buffalo N.Y.**

17. (a) **Burial** (b) Date thereof **April 12, 48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park C.**

18. (a) Signature of funeral director **William F. Horne**
(b) Address **215 So. Jefferson**

19. (a) **ADD 9 1948**
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **San**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2214 Spruce**
22 (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **6**
year **1948** hour **8** minute **10 p** M.
21. I hereby certify that I attended the deceased from
April 5, 19 **48** to **April 6** 19 **48**
that I last saw him alive on **April 6** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardio Vascular Disease Undet. Uremia**
Duration _____

Due to _____
Due to _____

Other conditions **Old Left Hemiplegia and Chronic Nephritis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **No**
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 place)
(e) Means of injury _____
23. Signature **Robert F. Daniels** (M. D. or other)
Address **2601 N Whittier** Date signed **4/7/48**

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.....

S. J. Watson

Licensed Embalmer No. *269 P*

P. O. Address *2769 Chestnut*

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.