

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 9 1948

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30804**
Registrar's No. **8509**

Registration District No. **318**

Primary Registration District No. **1003**

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:
ST. LOUIS MATERNITY HOSPITAL
(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 **MISSOURI** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS**
3937 COOK AVENUE
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **INFANT "A" ALCORN**
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 **9**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **SEPTEMBER 19 1948**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 hr. **20** min.

9. Birthplace **ST. LOUIS MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____

12. Name **FRANK ROY ALCORN**
13. Birthplace **ST. LOUIS MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **ADDIE MAE FORD**
15. Birthplace **CALDWELL ARKANSAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **ST. LOUIS MATERNITY HOSPITAL**
(b) Address **630 SO. KINGS HIGHWAY**

17. **Anatomical Board** (b) Date thereof **SEP 30 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Roeland Mat. Service**
(b) Address **4104 Manchester Ave**

19. (a) **SEP 30 1948** (b) **J. F. Bredack**
(Date received local health officer's report) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **SEPTEMBER 19**
year **1948** hour **3** minute **45P.** M.
21. I hereby certify that I attended the deceased from **SEPTEMBER 19**
19 48 September 19, 19 **48**
that I last saw him alive on **SEPTEMBER 19**, 19 **48**
and that death occurred on the date and hour stated above.

Duration
Immediate cause of death **Atelctasis**
Due to **Prematurity**
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? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Carl T. Wodley, M.D.** (M. D. or other)
Address **St. Louis Maternity** signed **119**

WRITE PLAINLY—USE 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.....

Licensed Embalmer No.....

P. O. Address.....

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.