

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

9349  
Do not use this space.

REC'D APR 11 1938

**1. PLACE OF DEATH**

(a) County..... Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003**  
 (c) City St. Louis (d) Street No. Homer G. Phillips Hospital Registered No. **2938**  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 1109a Glasgow Ave. St. **21**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** M **4. COLOR OR RACE** Negro **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word)

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)** 10-28-37

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
 3 4

**OCCUPATION**  
**8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.**  
**9. Industry or business in which work was done, as saw mill, bank, etc.**  
**10. Date deceased last worked at this occupation (month and year)** **11. Total time (years) spent in this occupation**

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** St. Louis, Mo.

**FATHER**  
**13. NAME** -----

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** -----

**MOTHER**  
**15. MAIDEN NAME** Hazel Walker

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Kentucky

**17. INFORMANT (ADDRESS)** E. M. Sherard, R. R. L. 2601 N Whittier St.

**18. BURIAL, CREMATION, OR REMOVAL**  
 PLACE City Cem DATE 3-31-38

**19. FUNERAL DIRECTOR (ADDRESS)** Ira Hamilton City Health Dept.

**20. FILED** **MAR 29 1938** *J. F. Prelick*  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** 12-2-38 19 37

**22. I HEREBY CERTIFY, That I attended deceased from**  
10-28-, 19 37, to 2-2-, 19 38

I last saw him alive on 2-2-, 19 38 Death is said to have occurred on the date stated above, at 10:45 p. m.  
 The principal cause of death and related causes of importance were as follows:

Prematurity

*157*

Date of onset  
10-28  
1937

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis? Clinical Was there an autopsy?.....

**23. If death was due to external causes (violence), fill in also the following:**  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?.....  
(Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

**24. Was disease or injury in any way related to occupation of deceased?**  
 If so, specify.....  
 (Signed) T. O. Marshall, M. D.  
 (Address) 2601 N Whittier St.

**STATEMENT BY LICENSED EMBALMER.**

I, ..... Licensed Embalmer No. ....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by .....  
..... L. E. ....  
No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

**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.)**