

REC'D JUN 9 1938

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

16956
Do not use this space.

791

1003

Registered No. 4817

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City St. Louis (d) Street No. Homer G. Phillips Hospital St. (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

Sanderson 536
(a) Residence, No. 1206 Leffingwell St. 21 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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) 5-20-38

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

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.

13. NAME

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

15. MAIDEN NAME Florence Sanderson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holly Springs, Miss.17. INFORMANT (ADDRESS) Ether M Sheward
2601 N Whittier St.18. BURIAL, CREMATION, OR REMOVAL PLACE City Cem DATE 5-27-3819. FUNERAL DIRECTOR (NAME) (ADDRESS) Ira Hamilton
City Health Dept20. FILED MAY 25 1938 J. D. Bredich Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-20- 1938

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at 3:42 A.M.

The principal cause of death, and related causes of importance were as follows:

Premature Stillborn

Date of onset

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) J. M. Hall, M. D.(Address) 2601 N Whittier St.

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, above space should be left blank.