

REC'D DEC 12 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH 791

37293  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003  
(b) Township ..... Primary Registration District No. 1003  
(c) City St. Louis (d) Street No. Homer Phillips Hospital Registered No. 9620  
(e) Length of residence in city or town where death occurred 22 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
*(If death occurred in Hospital or Institution, write its name instead of street and number)*

2. PRINT FULL NAME

Daniel Gholson  
(a) Residence, No. 1603 S 3rd St. 23 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 29, 1881  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
56 10 2  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
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) Mississippi

FATHER 13. NAME John Jackson

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

MOTHER 15. MAIDEN NAME Mary Gholson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

17. INFORMANT (ADDRESS) Evelyn Hilliard  
2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Jackson DATE 11-7-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. ...  
2625 Olive

20. FILE NO. NOV 5 1938 J. F. Bredek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 31 19 38

22. I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1938, to Oct. 31, 1938

I last saw him alive on Oct. 31, 1938 Death is said

to have occurred on the date stated above, at 7:30a.m.

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

Bronchopneumonia Date of onset 10/2/38

Other contributory causes of importance:

Arteriosclerosis  
Cardiac Hypertrophy

Name of operation ..... Date of .....

What test confirmed diagnosis? clinical Was there an autopsy? yes

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) W. J. ... M. D.

(Address) 2601 N Whittier

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.

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, me

or by A. D. Richardson

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision

Signed A. D. Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 Mascan

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County St Louis Registration District No. 791  
(b) Township ..... Primary Registration District No. 1003  
(c) City St Louis (d) Street No. .... 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

Daniel Gholson  
(a) Residence, No. .... St.  (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 ..... 4. COLOR OR RACE ..... 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) .....

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

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) .....

FATHER 13. NAME John Jackson

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

MOTHER 15. MAIDEN NAME Mary Gholson

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

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19

19. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED 1-14-39 J. B. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31, 1938

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the day started above, at ..... m.

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

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... 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) H. J. Legman, M. D.

(Address) .....

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

over

No information can be obtained in  
regard the name. Checked Hospital  
and undertaker and nearest  
known relatives. N. M. D.