

REC'D FEB 10 1939

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

306

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003** Registered No. **306**
 (c) City **Saint Louis** (d) Street No. **4210 W. Garfield Avenue** 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 **15** yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Ollie Eskridge**

(a) Residence, No. **4210 W. Garfield Avenue** St. **11** (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 **Female** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 10, 1891**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 **9** **28**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 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) **Brookhaven Mississippi**

FATHER 13. NAME **Peter Knight**

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

MOTHER 15. MAIDEN NAME **Mariah Lee**

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

17. INFORMANT (ADDRESS) **Henry Eskridge**
4210 W. Garfield Avenue

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **1/13/39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Charles J. Gates**
4107-09 Finney Avenue

20. FILE **JAN 10 1939** **J. D. Beckwith** Local Registrar

MEDICAL CERTIFICATE OF DEATH

No Physician in Attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **January 8th 1939**

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

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at **9:00** m. p.m.

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

Leabates
Chronic Myocarditis
Chronic Nephritis

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **N.O.**

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? **No**
 If so, specify.....
 (Signed) **Joseph M. ...**
 (Address) **1300 Clark Avenue**

STATEMENT BY LICENSED EMBALMER

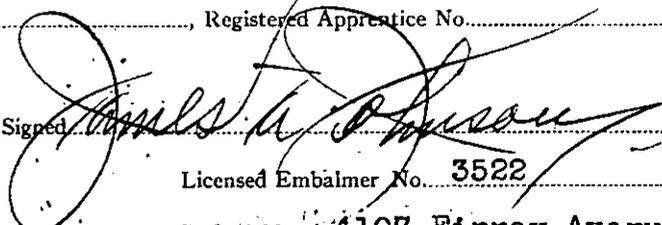
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. **3522**.....

P. O. Address **4107 Finney Avenue**.....

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.