

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.

REC'D FEB 10 1939

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

757
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City **St. Louis**
(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No. **791**
Primary Registration District No. **1008**
(d) Street No. **Homer G. Phillips Hospital** Registered No. **757**
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **2110 Gratiot** St. **22**
(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 **Undet.** 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) **12-30-38**

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

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) **St. Louis, Mo.**
(STATE OR COUNTRY)

FATHER 13. NAME **Fonzie White**

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

MOTHER 15. MAIDEN NAME **Ora Green**

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

17. INFORMANT **Arthur M. Sheward**
(ADDRESS) **2601 N Whittier St.**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **City Cem** DATE **1-26** 19**39**

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

20. FILED **JAN 25 1939** **J. B. Budick**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12-30-** 19 **38**

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, **1:00a.m.**
The principal cause of death and related causes of importance were as follows:

Unknown (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. B. Budick** 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.