2

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 MAR 13 1939

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

791

4421
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 1114
(c) City ..... (d) Street No. Homer Phillips Hosp. 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 Mr. William Alexandria
(a) Residence, No. 2333 Franklin Ave. St. 21 Homer G. Phillips Hospital
(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: male
4. COLOR OR RACE: colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 15 1912
7. AGE: YEARS 26 MONTHS 4 DAYS 14 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Barge Line
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) unknow
11. Total time (years) spent in this occupation 7 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

FATHER
13. NAME dont no
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) dont no

MOTHER
15. MAIDEN NAME dont no
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Lula Belle Johnson 1933 Carr St.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE 2-3- 1939
19. FUNERAL DIRECTOR (ADDRESS) Mrs. Lwsinda Thomas 2734 Sheridan Ave.
20. FILED FEB 3 1939 J. F. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH
NO ATTENDING PHYSICIAN

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/29/39 19
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 6:30 A. M.
The principal cause of death and related causes of importance were as follows:

Date of onset

Haemorrhage from gunshot wound of abdomen, inflicted at the hands of one James Anderson, in self defense, about 12:00 o'clock midnight January 27th, 1939, at 2013a

Other contributory causes of importance:
Franklin Avenue.

JUSTIFIABLE HOMICIDE

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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 1/27/ 19 39
Where did injury occur? St. Louis, Mo.
(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 See Above

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Joseph M. Quinn Deputy Coroner M. D.
(Address) .....

(Licensed Embalmer's Statement on Reverse Side)

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.)