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 4693 Do not use this space.

Registration District No. 1003 Primary Registration District No. Registered No. 1386

1. PLACE OF DEATH

(a) County
(b) Township
(c) City or Town 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 16 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank Luckett

(a) Residence, No. 220 Marion St. 23 (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: M
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: Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug. 1, 1904

7. AGE: Years 34 ~~35~~ Months 6 Days ~~29~~ 6 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.: Truck Driver
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: Jon Luckett
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

MOTHER
15. MAIDEN NAME: Jennie-(Unknown)
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

17. INFORMANT: Ethel Mae Skerard (ADDRESS) 2601 N. Whittier

18. BURIAL, CREMATION, OR ~~REMOVAL~~ PLACE Father Dickson DATE Feb. 13, 1939

19. FUNERAL DIRECTOR (NAME) Slotan & Koan (ADDRESS) 228 Orchard Ave & Big Bend

20. FILED FEB 13 1939 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-7-, 19 39

22. I HEREBY CERTIFY, That I attended deceased from 1-6-, 19 39, to 2-7-, 19 39
I last saw him alive on 2-7-, 19 39 Death is said to have occurred on the date stated above, at 4:10 m. A. M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Luetic Heart Disease	1-6-39

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? clinical Was there an autopsy? No

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. Lyman, M. D.
(Address) 2601 N. Whittier St.

(Licensed Embalmer's Statement on Reverse Side)

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 William C. McDowell; Registered Apprentice No. ..... working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. R114

P. O. Address 3306 Franklin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.