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

91

1003

4860
Do not use this space.

Registration District No.

Primary Registration District No.

Registered No. 1553

1. PLACE OF DEATH

(a) County

(b) Township

(c) City or Town: St. Louis

(d) Street No.: Homer Phillips Hospital St.

(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.

(If death occurred in Hospital or Institution, write its name instead of street and number)

Life

2. PRINT FULL NAME Tom DeClue

(a) Residence, No.: 2232a Clark 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
M	C	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 18, 1879

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	59	10	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: nil

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): St. Louis Missouri

FATHER

13. NAME: Xavier Declue

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

MOTHER

15. MAIDEN NAME: Elizebeth Smith

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

17. INFORMANT: Evelyn Hillierd
(ADDRESS): 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL
PLACE: National Cem. DATE: 2-20, 1939

19. FUNERAL DIRECTOR (NAME): Sennie Love
(ADDRESS): 3103 Washington Blvd.

20. FILED: FEB 17 1939 J. B. Burdick, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1939, to Feb. 14, 1939

I last saw him alive on Feb. 14, 1939. Death is said to have occurred on the date stated above, at 7:05p m.

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

	Date of onset
Arteriosclerosis	1/21/39

97

Other contributory causes of importance:
Pulmonary congestion, caused by arterio sclerosis. Non tubercular
No pneumonia

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

(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. 2118

P. O. Address 3506 Franklin

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

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