

1939 JUN 12 1939

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

791
1003

16611
Do not use this space.
4145

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No.
(c) City or St. Louis (d) Street No. Homer G. Phillips Hospital Registered No.
(e) Length of residence in city or town where death occurred (f) How long in U. S., if of foreign birth?
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. 2841 Chouteau 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 Male	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) 4-14-39				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day 20 hrs. or 20 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.			
	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, Mo.				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME Bernice Harris			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.			
17. INFORMANT (ADDRESS) Esther Mary Stewart 2601 N Whittier St.				
18. BURIAL, CREMATION, OR REMOVAL PLACE City Cem DATE 5-5-39				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Vera Hamilton City Health Dept.				
20. FILED MAY 4 1939 J. B. Budick Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-15-39**

22. I HEREBY CERTIFY, That I attended deceased from **4-14-39** to **4-14-39**
I last saw him alive on **4-15-39** Death is said to have occurred on the date stated above, at **1:10 p. m.**
The principal cause of death and related causes of importance were as follows:
Prematurity
Date of onset

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
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) **Wm E Smith** M. D.
(Address) **2601 N Whittier St.**

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.

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.