

JUN 12 1939

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

16785
Do not use this space.

1. PLACE OF DEATH

(a) County..... / Registration District No.....
 (b) Township..... / Primary Registration District No.....
 (c) City St. Louis, Mo. / (d) Street No. 1536 Papin St. Lary's Infirmary 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME ⁶³⁶ Buster Hardrick

(a) Residence, No. 3116 School St. 21
 (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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 9, 1888
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
51 50 6 26
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 4 1939
 22. I HEREBY CERTIFY, That I attended deceased from April 25 1939, to May 4 1939
 I last saw him alive on May 4 1939. Death is said to have occurred on the date stated above, at 2:37 A.M.
 The principal cause of death and related causes of importance were as follows:

Miliary Tubercu-
 losis & Perforation
 of intestine & lungs not
 involved. Date of onset

Other contributory causes of importance:
25
 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..... 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? None
 If so, specify.....
 (Signed) [Signature] M. D.
 (Address) 1536 Papin St St Louis Mo

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

FATHER 13. NAME Buck Hardrick

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

MOTHER 15. MAIDEN NAME Agnos Allen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

17. INFORMANT (ADDRESS) Jessie Graham
3116 School Street

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE May 9th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. L. Beal Und. Co.
2726 Lucas Ave.

20. FILED MAY 9 1939
[Signature]
 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X16603

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 *Birdie Beal Andersen*
Licensed Embalmer No. *2929*
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.