

REC'D JUN 12 1939

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

17322
Do not use this space.

791
1003

Registered No. 4856

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City or Saint 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 7 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lillie Bell Sinton
 (a) Residence, No. 4232a West Belle Place St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Cicero Sinton

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 25, 1915

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 2 1

OCCUPATION
 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month, day, year) 9-28 11. Total time (years) spent in this occupation Unk.

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

FATHER
 13. NAME Robert Settles
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unavailable Mississippi

MOTHER
 15. MAIDEN NAME Comata Smith
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Corinth Mississippi

17. INFORMANT (ADDRESS) Cicero Sinton 4232a West Belle Place

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE May 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Charles J. Gates 4107-09 Finney Avenue

20. FILED MAY 29 1939 J. D. Beck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 26th, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1939, 19... to May 26th, 1939
 I last saw her alive on May 26th, 1939 Death is said to have occurred on the date stated above, at 3:25p.m.
 The principal cause of death and related causes of importance were as follows:
Pulmonary tuberculosis Date of onset 2/27/39
Intestinal tuberculosis
 Other contributory causes of importance:
Intestinal tuberculosis
 Name of operation Date of...
 What test confirmed diagnosis Clinical 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? No.
 If so, specify
 (Signed) Malcolm L. Ingham M. D.
 (Address) Homer G. Phillips Hosp.

M. 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. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. I X16803

STATEMENT BY LICENSED EMBALMER

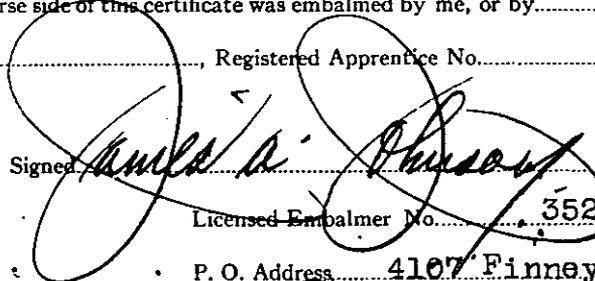
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No..... 3522

P. O. Address..... 4107 Finney Ave.

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.