

MAY 16 1939

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

19846
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township Carondelet Primary Registration District No. 200 Registered No. 890
(c) City Kennett or Kennett (d) Street No. Robert Kauls 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 yrs. mos. 24 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1409 Blair 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 <u>Male</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Separated</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Oliver Brooks</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-8-1916</u>		
7. AGE YEARS <u>22</u>	MONTHS <u>8</u>	DAYS <u>5</u>
If LESS than 1 day, hrs. or min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Trunk Driver</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Stel - U. P. A.</u>		
10. Date deceased last worked at this occupation: (month and year) <u>Dec - Jan - 1938-39</u>		11. Total time (years) spent in this occupation <u>></u>

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Miss13. NAME Vern Shepherd14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Miss15. MAIDEN NAME Rachel Mae16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Miss17. INFORMANT (ADDRESS) Rock Hospital Records18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE 5-18-3919. FUNERAL DIRECTOR (NAME) (ADDRESS) Atkins Bros
3644 Fairview Ave20. FILE MAY 16 1939 W. H. Miller Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-13, 193922. I HEREBY CERTIFY, That I attended deceased from 4-19, 1938, to 5-13, 1939.I last saw him alive on 5-13-39, 19..... Death is said to have occurred on the date stated above, at 4 P. m.

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

Pulmonary The
Intestinal The

Date of onset
1939?Other contributory causes of importance:
23

Name of operation..... Date of.....

What test confirmed diagnosis? Sputum 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) Fred A. Halderson M. D.(Address) Robert Kauls Hospital

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 *me*

Louis V. Atkins

Registered Apprentice No. _____

working under my personal supervision.

Signed

Louis V. Atkins

Licensed Embalmer No. *2842*

P. O. Address *3644 H. Finne*

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.