

Registration District No. 1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH: *29 Sheridan and*
 (a) County *St. Louis & H. Ford and*
 (b) City or town *St. Louis*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2906 Sheridan, St. V
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
 years, months or days)

8. (a) PRINT FULL NAME *LUCINDIA HAYES*

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex *female* 5. Color or race *Negro* 6. (a) Single, widowed, married divorced *widowed*

6. (b) Name of husband or wife *Unknown* 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *may 10 1884*
 (Month) (Day) (Year)

8. AGE: Years *55* Months *1* Days *0* If less than one day _____ hr. _____ min.

9. Birthplace *Unknown Georgia*
 (City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

11. Industry or business _____

MOTHER FATHER { 12. Name *Charley Bland*

13. Birthplace *Unknown Georgia*
 (City, town, or county) (State or foreign country)

14. Maiden name *Lucinda May*

15. Birthplace *Unknown Georgia*
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature *Dickinson Hayes*

(b) Address *4357 1/2 Bell*

17. (a) *Pickens, Miss.* (b) Date thereof *6/16 1939*
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Pickens, Miss.*

18. (a) Signature of funeral director *English Indico*

(b) Address *2931 S. & Olive*

19. (a) *J. B. Predeck* (b) _____
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *1*

(c) City or town *St. Louis* 21
 (If outside city or town limits, write "RURAL")

(d) Street No. *2906 Sheridan*
 (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *6* day *10*
 year *1939* hour *6* minute *00* A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Myocardial Occlusion

Due to *arteriosclerosis*

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury *fall*

23. Signature *Joseph M. ...* (Date signed *6/16*)

Address *...*

Date signed *6/16*

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.....
Louis V. Atkins....., Registered Apprentice No.....
working under my personal supervision.

Signed Louis V. Atkins
Licensed Embalmer No. 2842
P. O. Address 3644 Finney

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.