

20642

JUL 12 1939 **791**

Registration District No. **1008**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Homer Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **From 3/29/39 to**
(Specify whether _____)
In this community **6/17/39**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **Saint Louis** **1** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **3319 Lawton**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **John Isabelle**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NO**

4. Sex **M** 5. Color or race **C** 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 **December 16 1879**
(Month) (Day) (Year)

8. AGE: Years **59** Months **6** Days **1** If less than one day hr. _____ min. _____

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Janitor**

11. Industry or business _____

12. Name **Lawson Isabelle**

18. Birthplace **unknown Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Octavia Heath**
15. Birthplace **unknown Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Evelyn Willard**
(b) Address **2601 N. Whittier**

17. (a) **Burial** (b) Date thereof **6/21/39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fratherick**

18. (a) Signature of funeral director **Blum**

(b) Address **215 S. Jefferson**

19. (a) **JUN 20 1939** (b) **J. B. Brudick**
(Date received at local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **17**
year **1939** hour **7** minute **35** P. M.

21. I hereby certify that I attended the deceased from **March 29, 1939**
_____ 19____ to **June 17, 1939** 19____;

that I last saw him alive on **June 17, 1939** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Oro-pharyngeal carcinoma with gastrostomy **abt. 9 months**

Due to **Cachexia Emaciation**

Due to _____

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

Major findings: Of operations **normal stomach**

Of autopsy **no**

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 _____

23. Signature **J. W. Noyes** (M. D. or other) _____

Address **2601 N. Whittier** Date signed **6/19/39**

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.

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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*

Chas. Garris, Registered Apprentice No. *2349*

working under my personal supervision.

Signed *Chas. Garris*

Licensed Embalmer No. *2349*

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.