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

REC'D JUL 12 1939

20858
Do not use this space.

1. PLACE OF DEATH

(a) County ..... / Registration District No. 791

(b) Township ..... Primary Registration District No. 1003

(c) City or St. Louis / (d) Street No. Homer G. Phillips Hospital St. Registered No. 5702

(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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 623 Josephine Preston

(a) Residence, No. 1925 Whittier St. //

(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: F

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word):

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-16-39

7. AGE: Years | Months | Days | If LESS than 1 day, 8 hrs. or 40 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo. O

FATHER

13. NAME Thomas Preston /

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cincinnati, Ohio. O

MOTHER

15. MAIDEN NAME Aline Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

17. INFORMANT (ADDRESS) Esther Mae Sherrod 2601 N Whittier St.

18. BURIAL, CREMATION, OR REMOVAL PLACE CITY CEMETERY DATE 6-29-39, 19

19. FUNERAL DIRECTOR (NAME) Sra Hamilton (ADDRESS) City Health Dept.

20. FILED JUN 28 1939 J. B. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-17-, 19 39

22. I HEREBY CERTIFY, That I attended deceased from 5-16-, 19 39, to 5-17-, 19 39

I last saw her alive on 5-17-, 19 39. Death is said to have occurred on the date stated above, at 6:30 x. a. m.

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

Prematurity — Date of onset

Other contributory causes of importance:

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

What test confirmed diagnosis? Clinical Was there an autopsy? No

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? .....

If so, specify .....

(Signed) Wm. B. Smith, M. D.

(Address) 2601 N Whittier St.

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

X16605

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.