

REC'D AUG 11 1939 **791**  
Registration District No. **1003**

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: **1003**  
(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(c) Name of hospital or institution: Homer Phillips  
(d) Length of stay: In hospital or institution Since 4/25/39  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(d) Street No. 1325 N Garrison  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Nick Walker  
3. (b) If veteran, name war NO  
3. (c) Social Security No. NONE

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mary Walker 6. (c) Age of husband or wife if alive 41 years  
7. Birth date of deceased March 18, 1897

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>3</u>	<u>25</u>	hr. min.

9. Birthplace Mississippi  
10. Usual occupation janitor

11. Industry or business \_\_\_\_\_  
12. Name Ike Walker  
13. Birthplace Mississippi  
14. Maiden name Ada Ward  
15. Birthplace Mississippi

16. (a) Informant's own signature Mary C Bryant  
(b) Address 1923 1/2 Can St  
17. (a) Burial (b) Date thereof 7-17-39  
(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director Ellis Funeral Home  
(b) Address 2820 Stoddard St  
19. (a) JUL 17 1939 (b) \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 13  
year 1939 hour 3 minute 05 p. M.  
21. I hereby certify that I attended the deceased from Apr. 25, 1939  
to July 13, 1939  
that I last saw him alive on July 13, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic pulmonary tuberculosis  
Other conditions Tuberculosis of tongue  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature M Walker Allen  
Address 2601 N Whittier Date signed 7/15/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39  
U. S. DEPT. OF COMMERCE  
BUREAU OF THE CENSUS

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.

**21**

Duration

8-10 mo.

8-10 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 myself

Lonnie Boykins, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Lonnie Boykins

Licensed Embalmer No. 2946

P. O. Address St Louis Mo.

**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.**