

REC'D AUG 11 1939 **791**
Registration District No. **1008**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 2617 S. 12th
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME Baby McCall **240**

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

4. Sex Und 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased July 11, 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
hr. _____ min _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Verbie McCall

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Virginia McCall

15. Birthplace Ill
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph Van Tassan

(b) Address 1515 Lafayette Ave

17. (a) Funerary (b) Date thereof 7/29/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Joseph Van Tassan

(b) Address 1515 Lafayette Ave

19. (a) JUL 26 1939 (b) J. P. Baer
received local registrar (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day July
year 1939 hour 2:20 minute A. M.

21. I hereby certify that I attended the deceased from 7/11/39
_____, 19____, to 7/11, 19____

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

Immediate cause of death _____ Duration _____

Stillborn (Abortion)
Due to _____
Due to _____

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 1

23. Signature Julian F. Flynn (M. D. or other) _____

Address City Hospital Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....

....., 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 comply with the above constitutes grounds for revocation of license.)

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