

WHILE I LABOUR—USE CARBIDING BLACK INK—MAKE A PERMANENT RECORD

1 X1931

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.

Registration District No. **791**
1003

Primary Registration District No. _____

Registrar's No. **6718**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution: **2827 La Salle**
(d) Length of stay: _____

1939 SEP 14 1939

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Foetus Horde**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

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

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

7. Birth date of deceased **7-17-39**
(Month) (Day) (Year)

8. AGE: Years _____ Months **7 1/2** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **unk**

11. Industry or business _____

12. Name **Robert Horde**
13. Birthplace **Columbus Miss**
(City, town, or county) (State or foreign country)

14. Maiden name **Lucille Bell**
15. Birthplace **Columbus Miss**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Robert Horde**
(b) Address **2837 La Salle**

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director **Robert Horde**
(b) Address **3800 Putnam**

19. **AUG 1 1939** (Date received local registrar)
(b) **J.P. Brudick** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **1**
(c) City or town **St. Louis** **22**
(d) Street No. **2827 La Salle**
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **17**
year **1939** hour **8** minute **00 P.** 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 _____
Due to **Stell Boen**
Cause **unk**

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? _____
(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 **Joseph M. Quinn** (M.D. or other)
Address **Deputy Coroner** Date signed _____

Duration

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.....

....., 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.