

NOV 13 1939 791

Registration District No. 1000 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Enroute St. Louis Mo.  
 (a) County St. Louis  
 (b) City or town City Hospital  
 (c) Name of hospital or institution: 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County St. Louis  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") 25  
 (d) Street No. 4039 So. Broadway (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Phillip Boone  
 8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. 497-10-7204

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct, 1939, day 1, hour 5:20, minute PM  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Unknown  
 (Month) (Day) (Year)

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
 Immediate cause of death Myocardial Infarction Duration \_\_\_\_\_  
Fractures Skull

8. AGE: Years 52 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HYDRO PARK BREW

11. Industry or business Unknown

12. Name \_\_\_\_\_ 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Unknown 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hugh Hughes

(b) Address 4039 Broadway

17. (a) Burial (b) Date thereof 10-11-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Cedarwood

18. (a) Signature of funeral director D. J. ...  
 (b) Address 2849 N. ...

19. (a) OCT 2 1939 (b) \_\_\_\_\_  
 (Date received local registrar) (Signature)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically X

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Accident  
 (b) Date of occurrence Oct 1 1939  
 (c) Where did injury occur? St. Louis Mo (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 (Specify type of place) Full  
 (e) Means of injury \_\_\_\_\_  
 23. Signature James M. ... (M. D. or other)  
 Address Deputy ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

**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

Henry Tunisi, Registered Apprentice No. 7  
working under my personal supervision.

Signed Alfred Manfredi

Licensed Embalmer No. 5077

P. O. Address \_\_\_\_\_

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

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