

NOV 13 1939

791

State File No. _____
Registrar's No. **8433**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(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: **3842 Windsor**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **J**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **11**
(d) Street No. **3842 Windsor Pl.** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

8. (a) PRINT FULL NAME **Emma Harvey** **610**
3. (b) If veteran, name war **----** 3. (c) Social Security No. **----**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **28th** year **1939** hour **5** minutes **15 P.M.**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Unavailable** 6. (c) Age of husband or wife if alive **--** years
7. Birth date of deceased **Unavailable- 1866**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9/27** 19**39** to **9/28** 19**39**; that I last saw her **alive on 9/28/39** and that death occurred on the date and hour stated above.

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

Immediate cause of death
Cerebral hemorrhage
Due to **hypertension**
Due to **arteriosclerosis**

9. Birthplace **Unavailable** **Mississippi**
(City, town, or county) (State or foreign country)

Other conditions **absent**
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**
11. Industry or business _____
12. Name **Unavailable**
13. Birthplace **Unavailable**
14. Maiden name _____
15. Birthplace _____

Major findings:
Of operations _____
Of autopsy _____

MOTHER FATHER
16. (a) Informant's own signature **Paula Prager**
(b) Address **3842 Windsor Pl.**
17. (a) **Burial** (b) Date thereof **10/3/1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Father Dickson**
18. (a) Signature of funeral director **Chas. J. Gates**
(b) Address **4107 Finney Ave.**
19. (a) **OCT 2 1939** (b) **J. B. Rindick**
(Date received local registry) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(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? **no**
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **T. L. Walker** (M. D. or other) **1**
Address **809 N. Jefferson** Date signed _____

Duration **24 hr**
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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

DW
SEP 13 1948

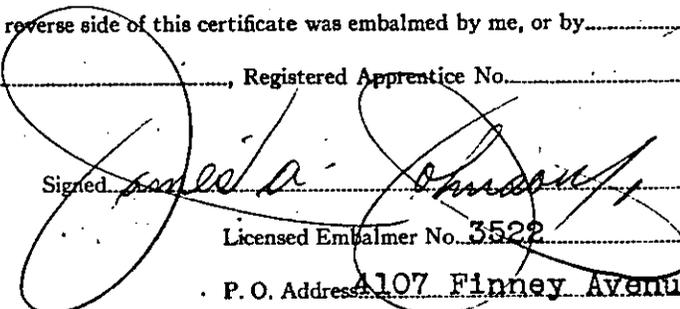
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No.

working under my personal supervision.

Signed 

Licensed Embalmer No. 3522

P. O. Address 1107 Finney Avenue

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.