

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

Rev. 5-17-39
U.S. GPO: 1939

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

NOV 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34764
Registrar's No. 9302

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 days
(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
(If outside city or town limits, write "RURAL")
(d) Street No. 2207 Chestnut
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME John Fox
8. (b) If veteran, name war _____ 8. (c) Social Security No. 200

4. Sex M 5. Color or race Negro
6. (a) Single, widowed, married, divorced Sep.
6. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 1 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 22
If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Jack Fox

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

14. Maiden name Matilda Thea

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

16. (a) Informant's own signature Arthur Mayo Sherard

(b) Address 2601 N. Whittier St.

17. (a) _____ (b) Date thereof 10-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, D.C.

18. (a) Signature of funeral director W. Brighton

(b) Address _____

19. (a) OCT 31 1939 (b) _____
(Date of local burial) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 23
year 1939 hour 5:05 minute A. M.

21. I hereby certify that I attended the deceased from 9-27-39 1939 to 10-23-39 1939
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease
Duration About 14 mos.

Due to _____

Due to Benign Nephrosclerosis

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.

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 _____

23. Signature W. C. Sherard (M. D. or other) _____

Address 2601 N. Whittier Date signed 10-25-39

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.