

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

37761

9620
Registrar's No.

9620

Registration District No. 1003

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1
 (b) City or town Saint Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (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 3 hours
 (Specify whether
 In this community 22 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town Saint Louis, -11-
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4352 Cottage
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Charles Anderson 531

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

4. Sex Male
 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lottie
 6. (c) Age of husband or wife if alive 54 years
 7. Birth date of deceased about 1876
 (Month) (Day) (Year)

8. AGE: Years about 63 Months - Days -
 If less than one day hr. _____ min. _____

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

10. Usual occupation Porter

11. Industry or business _____

MOTHER FATHER
 12. Name Unavailable 9
 13. Birthplace Unavailable 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Unavailable
 15. Birthplace Unavailable
 (City, town, or county) (State or foreign country)

16. (a) In decedent's own signature Charles Anderson

(b) Address 4352 Cottage Avenue

17. (a) Burial (b) Date thereof 11-12-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. J. Hayes

(b) Address 4107 Finney Avenue

19. (a) NOV 10 1939 (b) J. F. Brundick
 (Date received local registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 6,
 year 1939 hour 6 minute 15 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 Cerebral Hemorrhage (Apoplexy)
 Due to 82
 Due to _____
 Other conditions (Include pregnancy within 9 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)
 (a) Means of injury _____
 23. Signature J. F. Brundick (M. D. or other)
 Address 1800 Clark Avenue Date signed _____

STATEMENT BY LICENSED EMBALMER

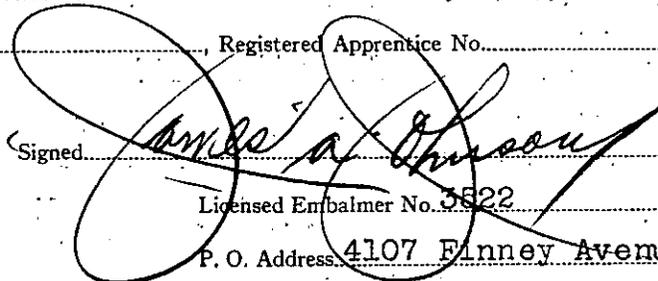
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

working under my personal supervision.

Registered Apprentice No.....

Signed



Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Avenue**

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.