

Registration District No. **791** Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County **1** St. Louis
(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 7 days
In this community Unknown
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **508** Foster Boone
3. (b) If veteran, name war. No. 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willie Boone 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Dec 8 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 11 3 hr. min.

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

10. Usual occupation Janitor

11. Industry or business _____
MOTHER FATHER { 12. Name Arthur Boone 2
13. Birthplace Canada ? (State or foreign country)
14. Maiden name Elizabeth ?
15. Birthplace Unknown (State or foreign country)

16. (a) Informant's own signature Willie Boone
(b) Address 4224a Page Ave.

17. (a) Removed (b) Date thereof 11-16-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Little Rock Ark.

18. (a) Signature of funeral director Wm C. McDowell
(b) Address 3506 Franklin Ave

19. (a) 11-16-1939 (b) J. B. Beck
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4224a -W Page Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 11
year 1939 hour 9:25 minute _____ P. M.
21. I hereby certify that I attended the deceased from 11-5- 1939 to 11-11- 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 7 days
Duration

Due to Hypertensive Heart Disease About
10 years

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.

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 H. J. Lyman (M.D. or other) 11-13-1939
Address 2601 J. Whittier St. Date signed

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.

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.....

William C. McDowell....., Registered Apprentice No.

working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2118

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.