

DEC 13 1939

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(c) Name of hospital or institution:
en route Homer G. Phillips Hosp.
(d) Length of stay: In hospital or institution 25 Years
In this community 25 Years

8. (a) PRINT FULL NAME Tom Waire
8. (b) If veteran, name war _____
8. (c) Social Security 600
N488-18-8738

4. Sex Male 5. Color or race Col
6. (a) Single, widowed, married, divorced Single
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)

8. AGE: Years About 56 Months _____ Days _____ 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 H. P. A.

12. Name John Waire

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

14. Maiden name Martina

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

16. (a) Informant's own signature Larry Bell Robinson

(b) Address 3413 1/2 Clark St.

17. (a) Amuril (b) Date thereof NOV 16 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Debrae

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

(b) Address 2620 Talbot Ave

19. (a) NOV 16 1939 (b) J. B. Bredbeck
(Date of death) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St Louis
(d) Street No. 2324 Pine Road
(e) If foreign born, how long in U. S. A. _____ years

20. DATE OF DEATH: Month Nov. day 12th
year 1939 hour 4.00 minute A. 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 Perforating Gastric Ulcer.
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operation _____
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature James M. Quinn
Address _____

WHILE 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.

1 X 3511

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 *Lyda Hughes*
Licensed Embalmer No. *2938*
P. O. Address *2620 Lawton*

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.