

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38329
Registrar's No. 10168

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hosp.
(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 Mo. (b) County 1
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 105 S. 22nd
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Evans 152

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10-27-39
(Month) (Day) (Year)

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

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name William Evans 1

13. Birthplace _____ Ga.
(City, town, or county) (State or foreign country)

14. Maiden name Ida Johnson

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

16. (a) Informant's own signature Father M. Sherard

(b) Address 2601 N Whittier

17. (a) Burial (b) Date thereof 11-30-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Dr. Hamilton

(b) Address City Health Dept.

19. (a) NOV 29 1939 (b) _____
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10- day 27
year 1939 hour 4 minute 45 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 _____

Unknown (Stillborn)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

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? _____ (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 J. B. Martin 11/25/39

Address 2601 N. Whittier Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Rev. 5-17-39

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.....
....., 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.