

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
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Hester 236

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 11-2-139
(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 Herman Hester

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

14. Maiden name Rose Scott

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

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

(b) Address 2601 N Whittier

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

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Ma. Hameltop

(b) Address City Health Dept

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 3141 Evans
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2
year 1939 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from _____, 19 _____ to _____, 19 39
that I last saw h. _____ 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 (M. D. or other) 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

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.

REC'D DEC 13 1939

11561-1 X-101

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.