

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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

40857

DEC 2 1939
 Registration District No. 200

Primary Registration District No. 200

State File No. _____

Registrar's No. 2114

1. PLACE OF DEATH:
 (a) County St Louis
 (b) City or town South KINLOCK PARK
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
#6 IRVINGTON 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St Louis
 (c) City or town South Kinlock Park
(If outside city or town limits, write "RURAL")
 (d) Street No. #6 Irvington
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME FRANCIS JAMES 5'2 1/2"
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 27
 year 1939 hour 6 minute 15 PM.

4. Sex FEMALE **5. Color or race** Colored **6. (a) Single, widowed, married, divorced** widowed
6. (b) Name of husband or wife John James **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased abt 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-16-1939
 _____, 19____, to 11-27, 19____;
 that I last saw _____ alive on _____ and that death occurred on the date and hour stated above.

8. AGE: Years abt. 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage
Due to hypertensive arteriosclerosis
Due to arteriosclerosis
Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name CABER HOMES

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

14. Maiden name Washington

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

16. (a) Informant's own signature Albe Sewell
(b) Address #6 Irvington

17. (a) _____ **(b) Date thereof** 12-3-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Travis
(b) Address 4059 Finney Ave.

19. (a) DEC 2 1939 (Date received local registrar) **(b)** W. R. Meyer (Registrar's signature)

Major findings: Of operations 82a1
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? _____
(Specify type of place) (b) Means of injury.

23. Signature Albe Sewell (M. D. or other) _____
Address 2220 W. Jefferson **Date signed** 11/29

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. 2114

P. O. Address 3506 Franklin Ave

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.