

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.

Registration District No. **2000** Primary Registration District No. **2**

1. PLACE OF DEATH:
(a) County **ST. LOUIS**
(b) City or town **ST. LOUIS**
(c) Name of hospital or institution: **2247A (R) RANDOLPH**
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME **IRENE FELIX 420**
8. (b) If veteran, name war **✓** 8. (c) Social Security No. **✓**

4. Sex **FEMALE** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced: **MARRIED**
6. (b) Name of husband or wife **ABE FELIX** 6. (c) Age of husband or wife **1889**
7. Birth date of deceased **ABT.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
ABT. 50 **✓** hr. **✓** min.

9. Birthplace **NASHVILLE TENN.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **JAMES GENTRY**

13. Birthplace **CHATTANOOGA TENN.**

14. Maiden name **EMMA COLEMAN**

15. Birthplace **NASHVILLE TENN.**

16. (a) Informant's own signature **abe felix**

(b) Address **2247A (R) RANDOLPH**

17. (a) **BURIAL** (b) Date thereof **12 9 39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **LOVE UND. CO. INC.**

(b) Address **3103 WASHINGTON BLYD.**

19. (a) **DEC 8 1939** (b) **J. J. Beulah**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **1**
(c) City or town **St Louis 22**
(d) Street No. **2247A (R) Randolph**
(e) If foreign born, how long in U. S. A. _____ years

No attending physician

20. DATE OF DEATH: Month **December** Day **5th**
year **1939** hour **9** minute **25 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Cirrhosis of Liver: Arterio Sclerosis**

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 **Joseph M. Gentry** (M. D. or other) _____
Address **Postoffice, Kansas** Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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 *Arthur P. Hilliard*

Licensed Embalmer No. *3389*

P. O. Address *3028 Dickerson*

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.