

Registration District No. 791

Primary Registration District No. \_\_\_\_\_

Registrar's No.

10637

1. PLACE OF DEATH:

(a) County Homer Phillip Hospital  
(b) City or town St Louis Mo  
(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Fred Little 340

3. (b) If veteran, name war no 3. (c) Social Security No. unknown

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased May 15 - 1888  
(Month) (Day) (Year)

8. AGE: Years 52 Months 11 Days 11 If less than one day hr. 5:27 min. PM

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

10. Usual occupation Labor

11. Industry or business \_\_\_\_\_

12. Name Tom Little

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

14. Maiden name Rhoda Duer

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

16. (a) Informant's own signature Frank Little

(b) Address 712 Carr St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-39 (Month) (Day) (Year)

(c) Place: burial or cremation Same as Father Dickson St

18. (a) Signature of funeral director E. L. Garner

(b) Address 2923 2829 Washington Blvd.

19. (a) Dec 12 1939 (Date received local registrar) (b) J. F. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1

(c) City or town St Louis 25  
(If outside city or town limits, write "RURAL")

(d) Street No. 712 Carr  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 26 year 1939 hour 5 minute 27 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 \_\_\_\_\_ Duration \_\_\_\_\_

Due to Cerebral Hemorrhage

Other conditions Office of Veterans Service

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury 4

28. Signature [Signature] (In. D. of Other)

Address [Address]

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

Rev. 6-17-39. Form 1-10-39

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.....

*Myself*  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Rex O Campbell*  
.....

Licensed Embalmer No. *3881* (City # *128*)

P. O. Address *St. Louis Mo*

**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.**