

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.

JAN 22 1939 791

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **11068**

1. PLACE OF DEATH: **11033**
 (a) County _____
 (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

3. (a) PRINT FULL NAME **McKnight 252**
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **Undet.** 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 **11-27-39**
 (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 _____

MOTHER FATHER { 12. Name **Alfred McKnight**
 13. Birthplace **Helena Ark.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Julia Brown**
 15. Birthplace **Pine Bluff Ark.**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Walter M. Sheridan**
 (b) Address **2601 N Whittier**

17. (a) _____ (b) Date thereof **DEC 27 1939**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **Ira Hamilton**
 (b) Address **City Health Dept.**

19. (a) **DEC 27 1939** (Date registered) (b) **J. T. Buehler** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County _____
 (c) City or town **St. Louis 21**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2012a 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 **27**
 year **1939** hour **5** minute **30 A. 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)** Duration _____

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

PHYSICIAN _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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) (a) Means of injury _____
 23. Signature **E. Mc Dowell** (M. D. or other) _____
 Address **2601 N Whittier** _____
 Date signed **12-23-39**

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.